Is psychiatry a crime against humanity?

Peter C. Gøtzsche
Institute for Scientific Freedom

Peter C Gøtzsche

Is psychiatry a crime against humanity?

Institute for Scientific Freedom

Is psychiatry a crime against humanity?

Cover: the author

ISBN: 978-87-85273-00-0
1. Edition, 1. Print
Printed in Denmark 2024

Institute for Scientific Freedom
Copenhagen
www.scientificfreedom.dk

Citation: Gøtzsche PC. Is psychiatry a crime against humanity?
Copenhagen: Institute for Scientific Freedom; 2024

Is psychiatry a crime against humanity?

Contents

Abbreviations

CDC: US Centers for Disease Control and Prevention
CI: Confidence interval
DSM: Diagnostic and Statistical Manual of Mental Disorders
FDA: US Food and Drug Administration
GSK: GlaxoSmithKline
NHS: UK National Health Service
NIMH: US National Institute of Mental Health
NNH: Number needed to treat to harm one patient
NNT: Number needed to treat to benefit one patient
SSRI: Selective serotonin reuptake inhibitor
WHO: World Health Organization

Acknowledgments

I am grateful for the generous help I got from Gabriel Symonds, Jim Wright, Yaakov Ophir, Will Hall, Ben Furman, Evgeny Legedin, and a reviewer who prefers to be anonymous who made comments and language revisions. I also want to thank Yaffa ShirRaz, Maria Kelly, Lee Combrinck-Graham, Redmond O'Hanlon, and David A Ward for their comments and the Critical Psychiatry Network, which accepted me as a member in 2013 and has a very active email discussion list.

1 Psychiatry is in crisis

We have a mental health crisis. The existing approaches that focus on drugs are not working. In the UK, mental health disability has almost trebled in recent decades, and the gap in life expectancy between people with severe mental health issues and the general population has doubled.[1] The World Health Organisation (WHO) and the United Nations have therefore recently called for systematic mental health reform emphasising psychosocial interventions.[2]

In 2019, a Norwegian study found that 52 of 100 consecutively admitted patients to a psychiatric hospital would have wanted a drug-free alternative if it had existed.[3] As I shall demonstrate in this book, psychosocial interventions are clearly better than drugs. Why can't people get that then?

According to the United Nations Convention on the Rights of Persons with Disabilities, it is unethical to subject patients to forced treatment.[4] There is a high risk that forced treatment is being used to benefit staff in making their work less stressful. In Europe, oversight comes under the convention prohibiting torture, and a committee has observed that deliberate ill-treatment of patients in psychiatric institutions still occurs.[5] Moreover, fundamental components of psychosocial rehabilitative treatment are underdeveloped or absent, and treatment consists essentially of drugs.

I have studied psychiatry closely for 17 years. I have published many scientific articles and several books,[6] given numerous lectures and interviews, and have been an expert witness in court cases about forced treatment or psychiatric drug harms in Brazil, Canada, USA, Ireland, Denmark, Norway, Sweden, Holland, Australia and New Zealand.

This book summarises what I have written before and contains a lot of new material as well. I include many debates I have had with psychiatrists to help historian and filmmaker Janus Bang who wants to write a biography about me, and I think these additions will be of general interest, as psychiatrists reason in the same way everywhere.

Undoubtedly, some will find the book's title provocative, but if you read the book, you can decide for yourself if you agree that psychiatry is a crime against humanity.

According to the Rome Statute of the International Criminal Court, Article 7, crimes against humanity refer to specific crimes committed in the context of a large-scale attack targeting civilians, regardless of their nationality.[7]

Crimes against humanity have often been committed as part of State policies. Prohibited acts include murder, imprisonment, torture, persecution against an identifiable group, and inhumane acts intentionally causing severe mental suffering or serious bodily injury.

State policies may lead to persecution of psychiatric patients. These patients have often described forced treatment as imprisonment and torture, and they have reported that their ill-treatment is sometimes deliberate. It is also a fact that State policies, in the form of clinical guidelines, may lead to much loss of life.

I have shown that psychiatric drugs are the third leading cause of death.[8] Depression drugs are the major killer, which is because so many elderly people take them. The pills double the risk of falls and hip fractures in a dose-dependent manner,[9] and within a year after a hip fracture, about one-fifth of the patients will be dead.

Doctors and drug regulators are surprisingly unconcerned about all these deaths. When patients die, doctors usually blame their illness rather than the drug or their own incompetence, or they simply don't know it was a drug death, e.g. if a patient becomes dizzy, falls, breaks a hip, and dies as a result. In contrast, airline pilots are critically concerned with our safety because if we go down, they do too.[10]

There are many examples of fraud and crime in psychiatry in my book. Fraud is any activity that relies on deception in order to achieve a gain.[11] In the USA, you can be convicted of consumer fraud, which are deceptive practices resulting in financial or other losses for consumers in the course of seemingly legitimate business transactions. Fraud becomes a crime when it is a "knowing misrepresentation of the truth or concealment of a material fact to induce another to act to his or her detriment" (Black's Law Dictionary).

My most important advice to patients

Usually, only a few people hold extreme views, but in psychiatry, the vast majority believe in a specialty built on myths, lies, and flawed research. This is very harmful for patients. You will learn more about this in the following chapters.

Therefore, even though there are exceptions, as a precaution, if you have a mental health issue, you should not see a psychiatrist. It is dangerous and might turn out to be the biggest error of your life.[12] Any contact with psychiatry is likely to lead to treatment with one or more psychiatric drugs that will harm you.

I have heard numerous stories from patients with a common theme. They had no idea how dangerous it was to become a psychiatric patient and trusted their doctors, until they found out many years later that their lives had been ruined.

I shall also warn against seeing a family doctor. As doctors are trained to use drugs, you will most likely be harmed. It is better to find someone who is good at talk therapy, e.g. a psychologist or psychotherapist, and if there is a long waiting list, it is usually better to do nothing.

Since you cannot trust what doctors tell you about mental health issues and psychiatric drugs, you might want to look up the evidence yourself. It is much easier than you might think.[13] If a doctor writes a prescription for a psychiatric drug, don't go to the pharmacy. Go on the Internet and find the officially approved package insert, e.g. by writing *Prozac FDA package insert*. If you read it, you'll likely know more about the drug than your doctor does. I am not joking. If doctors knew what is written in package inserts, they wouldn't prescribe so many drugs.

When you have read the package insert, you might decide not to take the drug. Psychiatric drugs are very rarely needed, and if so, only in acute situations, never long-term. You can also find much useful information on the Internet, but it requires quite some understanding of research methodology to be able to judge if what you find is reliable.

Why I took an interest in psychiatry

Readers will of course want to know why I took an interest in psychiatry. I am a specialist in internal medicine and had no particular interest in psychiatry when Margrethe Nielsen from the Danish Consumer Council contacted me in 2007. She wanted to compare benzodiazepines (drugs against anxiety and sleeping problems) and selective serotonin reuptake inhibitors (SSRIs, drugs against depression) to see if history was repeating itself.

I paid for her PhD out of my budget. We found that the withdrawal symptoms were very similar for the two classes of drugs, but they were described as dependence only for benzodiazepines.[14] To use different names for the same problem is irrational, but Danish

Lundbeck, a major seller of depression pills, called it “nonsense” that people could become dependent on them.[15]

This organised denial is still prevalent. In 2020, Maryanne Demasi and I showed that although 28 of 39 popular websites warned patients about withdrawal effects, 22 stated that SSRIs are not addictive, and only one stated that people “may get abstinence symptoms.”[16] The worst argument, which I have heard from many psychiatrists, is that the patients are not dependent because they don’t crave higher doses. If this is true, smokers are not dependent on nicotine because they don’t increase their daily consumption of cigarettes. Laypeople are more rational than psychiatrists and they consider the pills addictive.[17] Many patients cannot stop taking the drug because stopping makes them feel terrible, often worse than what they felt before they started on the drug.[18] The drug can seize control of their life. That’s what *addictive* means to most people.

Margrethe did three good studies, but her findings were not welcomed by two of her examiners, who had turfs to defend, Steffen Thirstrup from the Danish Drug Agency and general practitioner John Sahl Andersen. They rejected her thesis. The third examiner, psychiatrist David Healy, disagreed. This caused a delicate problem for the university, and an official called me on the phone. We solved the problem by treating the rejections, which were wholly unconvincing, as if they had been peer reviews. Margrethe responded to the comments and defended her thesis successfully.

Margrethe showed that when the use of benzodiazepines declined, it was compensated by a similar increase in the use of SSRIs.[19] Much later, Olivia Dinnage and I showed that there has been a similar explosion in dubious indications for SSRIs as we saw for benzodiazepines and before that for barbiturates. In addition to depression and anxiety, we found that over 200 diagnoses had been investigated in placebo-controlled trials.[20]

If the pharmaceutical companies are to be believed, no one can live a normal life without experiencing one or more psychiatric diagnoses. For example, Lundbeck’s drugs have been tested for compulsive shopping disorder and menopausal hot flushes.[21] We concluded that depression pills are the modern version of Aldous Huxley’s soma pill intended to keep people happy in *Brave New World*.

I have had seven PhD students in psychiatry and all of them have produced unique research results of great benefit to patients. Psychiatric leaders should have welcomed our results, but they – and other doctors entrapped in psychiatry’s mythology – although they disliked them intensely, had no valid counterarguments. Instead, they resorted to *ad hominem* attacks and often misrepresented what we had done to such an extent that it was mendacious, as you will see in the following. This also illustrates that psychiatry is in crisis.

One person has inspired me more than anyone else: science journalist Robert Whitaker from Boston. I met Bob for the first time in Copenhagen in 2012 when he explained in his lecture why antipsychotics (which I prefer to call neuroleptics) do more harm than good. I was sceptical because it went counter to my training. I knew a lot about clinical pharmacology and neuroreceptors and scored the highest mark at the exam when I studied medicine.

But when I had read Bob’s two outstanding books, *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill*,[22] and *Anatomy of an epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*,[23] and a lot else besides, I knew he was right.

We quickly became friends. It meant a lot to Bob that I had approved of his work, given my scientific reputation. Like many great people, Bob is kind, honest, and generous; he

always replies promptly to emails, no matter how busy he is. He is far better than most psychiatric professors in dissecting a piece of research and concluding, correctly, whether it is true or false. He is also a far better lecturer than almost everyone else I have listened to, and no one can fool Bob – he is too smart for that.

I came to publish many articles on his website, Mad in America, launched in 2012. It has six million unique visits every year,[24] and there are affiliated organisations in many countries, e.g. Mad in Brazil and Mad in Denmark. The importance of Bob's leadership cannot be overstated. Many patients have written to me that the books and articles by Bob or me have helped them get the courage to abandon their "career" in psychiatry and to taper off their drugs, discovering that a life without drugs is much better. There are many other books that have inspired patients to take control of their own life.[25]

In 2013, Bob invited me to give a lecture at the Safra Center for Ethics at Harvard University, to which he belongs. I met with the previous Editor-in-Chief of *New England Journal of Medicine*, Marcia Angell, who noted in the article, *The illusions of psychiatry*,[26] that psychiatrists should consider that other medical specialists, unlike psychiatrists, would be very reluctant to offer long-term symptomatic treatment without knowing what lies behind the symptoms, e.g. if a patient suffers from headache.

Angell has also pointed out how deeply corrupt American psychiatry is.[27] Court documents revealed that Charles Nemeroff and Alan Schatzberg published a psychiatry textbook in 1999 that was ghostwritten by GlaxoSmithKline.[28] In 2000, they co-authored a report of a depression pill trial where the authors had so many ties to drug companies that there wasn't room for them in the print version of her journal (they took up 1067 words on the web and Nemeroff and Schatzberg declared 17 industry ties each).[29] This led to Angell publishing the editorial: *Is academic medicine for sale?*[30] She explained it had been difficult to find a psychiatrist to write an editorial who was not conflicted.

I have lectured with Bob in the USA, Denmark, Norway, Sweden, Australia, and New Zealand. Every time, there were psychiatrists in the audience who agreed with us that the way we use psychiatric drugs causes far more harm than good.

In 2014, we lectured in Los Angeles at the annual conference of the International Society for Ethical Psychology and Psychiatry. The meeting title was *Transforming mad science and reimagining mental health care*. The press release announced that the speakers shared the belief that the medical model of care – the idea that distress and misbehaviour have physical causes that are best treated with drugs – is causing more harm than good.

It was a fascinating meeting that made it clear that we need a revolution in psychiatry. We must make it acceptable not to use drugs, even though mainstream psychiatry considers the drug-free approach irresponsible, dangerous and life-threatening. And we must explain just how oppressed and harmed the patients are by the quick fix mentality. The lectures have been made available.[31]

The organiser, psychologist David Cohen, gave me the Society's award for "Intellectual honesty and bravery in tackling the biomedical-industrial complex." He said that mental health authorities have acknowledged that biological or genetic research have not improved patient care, and that 50 years of increasingly sophisticated treatments have not reduced the burden of mental disorders but have increased it substantially.

The speakers included leading psychiatrists like Allen Frances and David Healy, psychologists, psychotherapists, social workers, neuroscientists, and a previous patient, Laura Delano, who calls herself a psychiatric survivor. This term says it all. In no other medical specialty do the patients call themselves survivors in the sense that they survived *despite*

being exposed to that specialty. In other medical specialties, the patients are grateful that they survived *because* of the treatments their doctors applied to them. If you have survived a heart attack, you won't do the opposite of what your doctor says. However, in psychiatry, you might die if you follow your doctor's advice.

Many survivors have described psychiatry as imprisonment, a facility where there is a door in but no door out. Laura described how small groups of people support each other in coming off psychiatric drugs, de-indoctrinating themselves from the biological model of mental illness. When she read Bob's second book, she realised that she could reclaim her humanity and free herself from the prison of psychiatric "care."

Laura had become dehumanised by psychiatry and was called treatment-resistant; she was on five drugs. Even her drug-induced weight increase was given a psychiatric diagnosis: binge eating. Bob's book saved her and helped her live with her pain more peacefully until she had built up enough faith in herself to heal, realising that she should not believe everything her mind was telling her, as it was still under the influence of drugs.

After she had come off her drugs, she was completely normal.

Laura connects with many clinicians who are slowly coming to understand the inefficacy and harm of their treatments but feel powerless and are afraid to do anything differently, fearing they could lose their licenses, face a lawsuit, get fired, or not get promoted.

Laura and I spoke at a meeting at the World Congress in Psychiatry in Berlin in 2017, arranged by Peter Lehmann, a German reformer. When I spoke about withdrawal from psychotropics, there were around 150 psychiatrists in the audience, and the atmosphere was hostile. Several people asked irrelevant questions, e.g. if I didn't believe that lithium worked? We had not discussed this drug at all.

Fifteen minutes later, I gave a talk about why psychiatric drugs are the third leading cause of death. Three psychiatrists out of the over 10,000 participants at the congress attended and they refused to give interviews and carefully avoided being filmed by a documentary film team that followed me, as if they were on their way to see a porn movie!

My wife Helle Krogh Johansen, a professor of clinical microbiology, and I celebrated Laura's wedding north of Göteborg in June 2022. It was the first time during the COVID-19 pandemic we behaved as before the pandemic, hugging people and kissing the beautiful bride – as they say in America: "You may now kiss the bride." Like many other guests, we came home with the virus made in China,[32] even though we had been vaccinated twice.

Some psychiatrists are slowly waking up to the tragedy they have created, and some mainstream journals, e.g. the *British Journal of Psychiatry*, now publish papers that are critical of the biological model of psychiatry, which assumes that mental illness is a result of a malfunction in the body and not a result of psychosocial factors, which is what most patients believe. In essence, this is the difference between saying: "There is something wrong with you," and, "There is something wrong in your life, the way you treat yourself or have been treated by others."

Psychiatrists have not been able to explain what exactly they mean by the biological model,[33] and one paper in the above-mentioned journal stated that research into putative biological mechanisms of mental disorders has failed to deliver anything of value to clinicians and was very unlikely to do so in the future.[34] Another paper predicted that the biology-based model would be ruinous to the profession due to its consistent failure to deliver.[35] These realistic statements come after many billions have been wasted on false leads in biological psychiatry.

The names of the drugs are also deceptive.[36] It makes sense to talk about antibiotics, as they can cure infections. A chemical cure for mental diseases doesn't exist. Antipsychotics don't cure psychosis, antidepressants don't cure depression, and anti-anxiety drugs don't cure anxiety. In fact, these drugs can *cause* psychosis, depression, and anxiety, particularly if used long term and when people try to get off them.

Psychotropic drugs have been developed based on rat experiments and selected if they disrupt the rat's normally functioning brain.[37] They cause a wide array of effects in people, just like street drugs and alcohol. And they are not in any way targeted, e.g. there is nothing selective about so-called selective serotonin reuptake inhibitors – yet another misleading name. There are serotonin receptors throughout the body, and the drugs have many other effects than merely increasing serotonin.

Psychiatric drugs work in the same way in patients, healthy volunteers, and animals. Common effects are numbing of feelings, emotional blunting, drowsiness, lack of control over your thoughts, caring less about yourself and others, and reduced or absent capacity for having sex and falling in love.

A person responding to one of my tweets noted that these drugs aren't "medications" (used to treat genuine physical illnesses) but neurotoxins (used to suppress normal brain functioning), and that, to refute psychiatric myths, we must begin by rejecting the mis-leading language.

The director of the US National Institute of Mental Health, Thomas Insel, has pointed out that there is no evidence of reduced morbidity or mortality from any mental illness from new drugs developed over the last 20 years, and that there is little evidence that the prospects for recovery have changed in the past century.[38] As he noted, this is in striking contrast to the steadily decreasing mortality rates for cardiovascular disease, stroke and cancer.

But what the public has heard about is the opposite: reforms, revolutions, progress, innovations, and paradigm shifts.

The lies have been brutal. Bob Whitaker has shown that the rate of disability pensions follows the usage rates for depression pills closely, and that after SSRIs came on the market, a 35-fold increase in disabled mentally ill children in the USA was seen in just 20 years.[39]

As I aim to demonstrate below, psychiatry does not deliver what patients want and what is most effective, that is, psychotherapy and other psychosocial interventions. If psychiatry had been a business, it would have gone bankrupt decades ago. The reason it has survived for so long, with its inappropriate focus on biomedical explanations and drugs, is that leading psychiatrists have lied about what their specialty achieves.

This may sound harsh, but you will see that it is correct. There is a huge divide between the psychiatric narrative and what the science shows. Indoctrination is therefore needed to make people believe in all the falsehoods. Students of medicine, psychology and psychiatry, and the allied health professions, learn about psychiatry by reading psychiatric textbooks. This is where the indoctrination starts.

In 2022, I read the five most used textbooks in Denmark[40] to see what students are taught at our universities and I describe what is wrong with these books in my *Critical psychiatry textbook* (freely available on my website[41] and in a serialised version on Mad in America[42]). It is being translated into Spanish by a psychiatrist who worries she might be fired when she starts using it for lecturing students in Argentina!

In a book review in *Psychosis*, social worker Tom Federn wrote that it is "an excellent book, extremely well-documented and clearly written but, because of its content, reading it can be a very upsetting experience."[43] Well, the truth about psychiatry always seems to be upsetting. Federn also says:

"The author asserts that so long as establishment psychiatry believes that research into the biological mechanisms of mental and behavioral activity can be of value, it cannot be of any real assistance to the so-called mentally ill beyond sedating them but at the terrible price of exposing them to potentially lethal or disabling side-effects. He predicts that sooner or later this situation will lead to the ruination of the profession ... the author points out that the last psychosocially orientated document produced by the National Institute of Mental Health was issued in 1961 … I would like to conclude this review on a personal note by paraphrasing the famous folk singer, Bob Dylan. How can the lives of such patients be in the palms of such apparent fools' hands? To see them so badly mistreated couldn't help but make me feel ashamed to be part of a profession involving the gross mistreatment of so-called psychiatric patients."

The authors of the textbooks I critiqued include some of the most prominent Danish professors of psychiatry, but I uncovered a litany of misleading and erroneous statements about the causes of mental health disorders: If they are genetic, if they can be detected in a brain scan, if they are caused by a chemical imbalance, if psychiatric diagnoses are reliable, and what the benefits and harms are of psychiatric drugs and electroshocks.

Much of what is claimed amounts to scientific dishonesty; various author groups sometimes provide contradictory messages within the same book; and it was my impression that the more implausible the claims, the less likely they were referenced. Logical thinking was not in abundance in these books, which looked more like religious testimonies than science, with many non-existent wonders being described.

One textbook called it a psychopharmacological revolution that we can alleviate or cure 80–90% of people with severe depression, and that patients with schizophrenia can become cured too. Well, if we wait long enough, most patients will improve, but this is not a drug effect.

In a chapter on psychopharmacology, three psychiatry professors, Anders Fink-Jensen, Poul Videbech, and Erik Simonsen, glorified the drugs.[44] They claimed that knowledge of brain functions has increased dramatically over the last half century; that our understanding of the mechanisms of the drugs' effects has been strengthened; that new drugs with fewer harms and better effects have been developed; that there is no doubt that this has decisively contributed to better psychiatric treatment for the benefit of the patients and their relatives; and that it is lack of compliance in psychotic patients that leads to relapse and readmissions. All these claims are so blatantly false that it is fair to call them lies.

Another textbook, which Videbech edited, claimed that drugs are very often needed, both in the acute phase and long-term to prevent relapse; that specific drug treatments have been known for about 65 years; that the drugs are generally effective and safe; and that the new psychiatric drugs are highly beneficial.[45] The truth is that no psychiatric drug has specific effects; the drugs rarely have clinically relevant effects and are therefore rarely needed; an effect on relapse has not been demonstrated; and the drugs are not safe.

Denial of the facts is what characterises the psychiatric profession. Leading psychiatrists have no problem with claiming the opposite of what the science shows. They do this all the time. This makes them – sorry for being blunt – habitual liars.

Let's start with the entry ticket to a psychiatric career: the diagnosis.

Psychiatric diagnoses are unreliable

Creating many diagnoses means big business, fame, and power.[46] The criteria for making a diagnosis are continually being lowered, which means more customers. In 1990–92, 12% of the US population aged 18–54 years received treatment for emotional problems; in 2001–2003, it was 20%.[47] In 2012, the US Centers for Disease Control and Prevention (CDC) reported that 25% of Americans have a mental illness.[48]

The definitions of psychiatric disorders are vague and unreliable,[49] but the psychiatrists don't convey this information. There was very little in the five textbooks that even hinted at the fact that psychiatric diagnoses are based on arbitrary criteria; that there is large inter-observer variation when several psychiatrists assess the same patients independently; or that most healthy people can be diagnosed with one or more mental illnesses if tested.[50]

There are often tautologies – circular evidence – in texts about diagnoses. One textbook noted that the diagnosis is conformed or rejected based on the treatment results. But if we give everyone a diagnosis of schizophrenia, and some become better, this cannot prove the diagnosis.

The American Psychiatric Association has proclaimed that major depressive disorder negatively affects how you feel, the way you think, and how you act.[51] This is also wrong. The Association blew life into something that is just a name – a description of a cluster of symptoms - and therefore cannot cause anything. If a patient is feeling low and the psychiatrist replies that this is because she has depression, it is a tautology, or a logical fallacy. A classification is used only to *describe*, not to *explain*, and a description cannot explain itself. Low mood and depression are synonymous.[52]

A review of 30 authoritative health organisation websites showed, however, that 16 of them explicitly described depression as causally responsible for the symptoms or used language that was both descriptive and causal.[53] For example, the World Health Organization stated that depression "can cause the affected person to suffer greatly and function poorly at work, at school and in the family."

The term "major depressive disorder" is frightening and contradictory, as it includes cases of mild depression which are neither major, nor depression, nor even a disorder.[54] But the propaganda works. Who would decline professional help if suffering from a major cardiac disorder?

Tautologies are also prevalent in the media. Even websites critical of overdiagnosis may convey information like, "Mental disorders are the leading causes of ill-health and disability worldwide."[55] Not so. People suffering from deprivation, poverty, unemployment, and abuse suffer ill health and disability; they are not attacked by a psychiatric monster, e.g. an imaginary disease called depression.[56] They become depressed because they live depressing lives.

In 2023, the WHO noted that "Mental health and well-being are strongly associated with social, economic, and physical environments, as well as poverty, violence, and discrimination. However, most mental health systems focus on diagnosis, medication, and symptom reduction, neglecting the social determinants that affect people's mental health … The widespread human rights violations and harm caused by mental health systems has led to a legacy of trauma that impacts many individuals and communities and spans generations."[57]

Few doctors know that the accuracy of a test depends on the disease prevalence.[58] The rarer a disease is, the more false positives will there be. This is why screening for mental health issues is a bad idea. The screening test for depression recommended by WHO was so

poor that for every 100 healthy people screened, 36 would get a false depression diagnosis.[59] Imagine if you screened healthy people for cancer with a test that gave a third of them an erroneous cancer diagnosis. We wouldn't allow this.

Poul Videbech claimed I was wrong when I said that a depression diagnosis was based on a simple test, and he argued that more conversations were needed.[60] However, he blamed me for his own mistakes.[61] Earlier, Videbech, on behalf of the Danish Board of Health, had recommended screening over one million Danes who should fill in a questionnaire with their general practitioner, "And if the questionnaire shows signs of depression, the doctor can start treatment," Videbech said.[62] Many patients have reported that there was no further testing and that they got a diagnosis and a prescription in about ten minutes.[63]

Curiously, after a Cochrane review had recommended against screening for depression,[64] the Danish Board of Health recommended screening for a huge number of poorly defined "risk groups."[65] When I pointed out, as an invited speaker at large scientific meetings for psychiatrists, that this would lead to treatment of many healthy people with depression drugs, they didn't pay the slightest attention, and, on one occasion, professor of psychiatry Lars Kessing replied that it didn't matter that we treated some who are healthy, because SSRIs have no side effects![66] He also said: "Screening cannot do harm."

Four of the five textbooks did not mention a single result from observer variation studies, where two or more psychiatrists suggest a diagnosis for the same patients. They gave the erroneous impression that psychiatric diagnoses are valid and reliable. The disappointing results of observer variation studies have been buried in positive rhetoric in surprisingly short articles, given the importance of the subject. This documentation is very hard to find, but two researchers found it.[67] The largest study, of 592 people, showed very disappointing results even though the investigators took great care in training the assessors.[68] For major depression and schizophrenia, for example, two of the most important diagnoses, the kappa values were only 0.64 and 0.65, respectively. This level of agreement between two observers is a very poor one. A value of 0.64 means that the difference between observed agreement and chance agreement is only 64% of the difference between perfect agreement and chance agreement.[69]

One textbook noted that the number of patients diagnosed with schizophrenia had quadrupled in 40 years. The authors did not comment on this stunning finding, even though it showed that the diagnosis cannot be trusted. A psychiatrist wrote to me that he had a massive breakdown in his twenties but resisted all psychiatric labels and medical treatments. Looking back, he realised how easily he could have been labelled schizophrenic, as he heard voices and had delusions and severe anxiety.

When a doctor meets a new patient, the doctor's first impression and past experience may very quickly suggest a particular diagnosis, and that initial impression all too easily becomes a self-fulfilling prophecy. There is a considerable risk that from the moment a particular diagnosis comes to mind, the doctor asks leading questions, which then yield the required number of positive answers and so confirm the expected diagnosis.

There is much overlap in the criteria for different diagnostic categories, which often results in a "comorbidity" label, although the patient does not have several "diseases." We would not accept this in any other branch of medicine. Indeed, prominent psychiatrists including the director for the NIMH, Thomas Insel, his predecessor Steven Hyman, and Allen Frances, chairman for the DSM-IV diagnosis manual, have acknowledged that psychiatric disorders have never been validated as discrete illnesses, and that the diagnostic categories are constructs.[70] Hyman has even admitted that diagnoses are "an absolute scientific night-

mare. Many people who get one diagnosis get five diagnoses, but they don't have five diseases – they have one underlying condition."[71]

We discussed diagnoses at the *Too much medicine* meeting in Helsinki in 2018, and I used a joke to explain that having a diagnosis is not the same as suffering from it:

"Does Donald Trump suffer from a mental disorder?"

"No, he enjoys it, but everyone else suffers!"

Allen Frances also lectured, and he spread my joke to the whole world on Twitter.

Psychiatric diagnoses can lead to stigmatisation and misery, and they can make it difficult to get education, work, insurance, certain pensions, approval for adoption, child custody, or even just to keep a driver's licence.[72]

I have met with Australian psychiatrist Niall McLaren who has written an instructive book telling us that anxiety is a key symptom in psychiatry.[73] If doctors don't take a careful history, they might miss that the current episode of distress, which they diagnose as depression, started as anxiety many years earlier when the patient was a teenager. As I shall explain later in this book, these patients should be treated with psychotherapy, not depression pills.

Niall explains why biological psychiatry is so popular among psychiatrists: "It isn't necessary to talk to a patient beyond asking a few standard questions to work out which disease he has, and that can easily be done by a nurse armed with a questionnaire. This will give a diagnosis which then dictates the drugs he should have."

Psychiatry has become dehumanised and industrialised. Find x "faults" with the patient out of y, that's all. You don't have to waste time talking with patients to find out what happened to them and how you might best help them. Soon, Artificial Intelligence might replace human interaction with patients, and we shall end up with an assembly line of diagnoses and drug prescriptions, saving doctors' precious time and earning them more money.

In the spirit of the thinking behind the DSM, I have invented a diagnosis for healthy people: Adult Symptom Deficiency Disorder (ASDD).[74] I was inspired in this by a cartoon by Randy Glasbergen in which a doctor tells a patient, "We can't find anything wrong with you, so we're going to treat you for Symptom Deficit Disorder." There are 10 questions and no matter what score you get between 10 and 30, there is always a treatment option.

The harmful lie about having a chemical imbalance

To motivate patients to take drugs they don't like because of their adverse effects, or are afraid of, psychiatrists have invented the lie that the patients' disorder is caused by a chemical imbalance in their brain, and that a drug will fix it.

According to the mythology, depression is due to low serotonin, schizophrenia to high dopamine, and ADHD to low dopamine; and treatment with psychiatric drugs is equally targeted towards the cause of the disease as when we give insulin for diabetes.[75]

Research has never demonstrated a chemical imbalance being the cause of depression[76] or any other mental disorder. Depression is not the result of a faulty brain but a normal brain responding to stress or adversity.[77] There are many examples that run counter to the idea that depression is caused by a deficit in serotonin.[78] For example, tianeptine, marketed for treatment of depression, lowers serotonin, and mirtazapine, also marketed for depression, does not affect serotonin. Furthermore, mice genetically depleted of brain serotonin behave like other mice, and monoamine levels in the brain increase in 1–2 days after the start of

treatment at a time when there is no difference between drug and placebo in depression scores, which comes much later and is very small.

The strong belief in this erroneous hypothesis was demonstrated by a survey showing that 80% of patients with depressive or bipolar disorder agreed with the statement that, "Antidepressants correct the changes that occurred in my brain due to stress or problems."[79] Another survey found that 92% of US university students had seen, mostly on TV, or heard, that depression is caused by a chemical imbalance.[80]

Most leading psychiatrists even lie about their lies. US professor of psychiatry Ronald Pies described chemical imbalance as an "urban legend, never a theory seriously propounded by well-informed psychiatrists," but the American Psychiatric Association has propagated the legend numerous times: "Antidepressants may be prescribed to correct imbalances in the levels of chemicals in the brain."[81] Pies was so dishonest that he blamed the legend on "opponents of psychiatry" who "mendaciously" attributed it to psychiatrists.

Thomas Middelboe, chair of the Danish Psychiatric Association, described chemical imbalance as a metaphor he might use because "We are dealing with neurobiological processes that are disturbed."[82] But psychiatric disorders do not start with disturbed neurobiology. If someone shows there is a difference in dopamine levels between patients with schizophrenia and healthy people, this cannot tell us anything about what started the psychosis. If a house burns down and we find ashes, it doesn't mean the ashes set the house on fire.

If a lion attacks us, we get frightened and produce stress hormones, but it wasn't the stress hormones that made us scared. People with psychoses have often suffered traumatic experiences in the past,[83] so if they have any "chemical imbalance," it is more likely to be the result of the psychosis rather than its cause.[84]

Leading psychiatrists often contradict themselves to get off the hook. In 2013, Videbech said that advising people to stop taking their antidepressant was like advising patients with diabetes to drop their insulin.[85]

In 2014, Videbech said that psychiatric disorders are not caused by an imbalance in the brain,[86] but eight months later, he said something else at a large public meeting arranged by medical students. After I had explained why far too many people are treated with depression pills and suggested we taper off them, Videbech said: "Who would take insulin from a diabetic?"

In 2015, when my first psychiatry book came out, Videbech said in an interview in the newspaper *Politiken* about me:[87] "Against better knowledge, he assigns to his opponent all sorts of unfair motives. For example, we have known for the last 20 years that the theory of the chemical imbalance in the brain for depression is far too simple. I have written about this in my textbooks for many years. It is therefore totally off limits when I and others are assigned such views."

Obviously, the lie about the chemical imbalance is only a thing of the past when challenged. Psychiatry professor Birte Glenthøj was also interviewed and confirmed the lie: "We know from research that patients suffering from schizophrenia have on average increased formation and release of dopamine, and that this is linked to the development of the psychotic symptoms." I noted how wrong the professors were, also in *Politiken*.[88]

In 2015, Psychiatry in the Capital Region held a large meeting at my hospital with the title, *Falsehoods and truths about psychiatric drugs*.[89] The occasion followed a prolonged debate about psychiatric drugs I had started a year earlier, and the chair started the meeting with a long introduction covering the ten myths I had described (see page 132)[90] but without

mentioning my name. A former patient asked why the person who had started the debate was not an invited speaker, and Kessing replied that people would not be able to follow a scientific debate between professors. But if the audience could follow three professors' presentations, they could probably also follow a discussion between four professors.

Officially, the aim of the meeting was to provide "a neutral and sober assessment of the drugs," but its true purpose was to protect the status quo.

Professor Merete Nordentoft launched two horrible falsehoods: that patients with schizophrenia live longer when they take antipsychotics and that only 3% relapsed in the first year on drugs, while 77% relapsed when the medication was discontinued (see Chapter 5 on psychosis). Only two of the studies she referred to had a placebo group, and one of these two studies had only 7–8 patients in each group.

Kessing delivered many falsehoods about depression drugs: that they prevent depression (like Nordentoft's way of arguing, this idea is also based on studies where the patients in one group have been exposed to abrupt quitting (cold turkey); that they don't increase the risk of suicide in healthy people; that they can be used in young people because they don't increase the risk of suicide; and that the patients don't become dependent on them (even though his own study of patients' experiences had shown exactly this[91]). (See also Chapter 2 on depression).

Professor Kerstin Plessen's falsehoods included the statement that we could see changes on brain scans in children with ADHD; that ADHD is strongly hereditary (with an 80% concordance between identical twins); and that ADHD drugs improve social functioning, reduce the risk of crime, and possibly also reduce substance abuse (see Chapter 4 on ADHD).

So, ironically in the extreme, all three professors made the meeting one of falsehoods, and he who could tell the audience the facts, wasn't invited.

Psychologist Olga Runciman pointed out that the chemical imbalance story was dead in other countries and asked if it wasn't also dead in Denmark. None of the professors replied, and the chair didn't hold them to account, not even after I had said, twice, that they hadn't replied.

Jens Peter Dam Eckardt Jensen, chief analyst at the patient association *Better Psychiatry*, told a very different story. He mentioned a study from 2013 of the relatives' views on psychiatric drugs:

Only one in five are confident that mentally ill people are treated with the correct medication and that the healthcare staff react in a timely manner if the patient experiences side effects from the medication.

Three out of four are worried about the patient's state of health because of the medication.

One person in two has experienced that the patient has been given the wrong combination/dose of medicine.

More than four out of five have experienced that the patient has had side effects from the medication.

Four out of five believe that medical treatment is used too much compared with other forms of treatment (therapy, physical activity, and the like).

One in five has at some point been concerned that the medical treatment has been life-threatening for the patient.

This last statement was devastating for the fairy tale the professors provided about psychiatry.

Eight months later, I emphasised in an interview that many patients end up taking drugs for the rest of their lives because they have been fooled by the chemical imbalance lie or have been told they will become brain damaged if they don't take the drugs.[92]

Psychiatrist Lars Søndergård said he didn't know of any psychiatrist who attributed mental illness to a chemical imbalance,[93] to which another psychiatrist, Julius Nissen, responded: "I have spent my many years in psychiatry talking to a lot of people who have received exactly this explanation and the comparison with insulin, that it is a substance they need. This conviction makes it very hard to motivate them to withdraw from the drug. It is precisely because they, during the withdrawal, de facto experience a 'chemical imbalance,' now that the brain is accustomed to the substance. They therefore feel confirmed that the hypothesis is true because they are ill, even though it is the side effects that must be overcome."

That the patients don't have a chemical imbalance to begin with but that their drugs create one was acknowledged already in 1996 by Steven Hyman, former director of NIMH.[94]

In 2017, Videbech postulated again that depressed people have an imbalance in the brain, on the website of the Psychiatry Foundation.[95] And, in their two articles in the web-based Handbook for Patients, which has official status in Denmark, he and Kessing both claimed this.[96] I complained to the editor four times[97] but got nowhere. They changed a few minor things and introduced new claims that made their articles even worse. They now wrote, without references, that antidepressants stimulate the brain to make new nerve cells. If true, it would only mean that the pills harm the brain, as it makes new cells in response to a brain injury.[98]

I complained again, and again to no avail, and the lie about the chemical imbalance continued.

Can you imagine a cardiologist saying, "You have a chemical imbalance in your heart, so you need to take this drug for the rest of your life," without having a clue what he or she is talking about? This lie will probably never disappear. In 2019, Maryanne Demasi and I collected information about depression from 39 popular websites in 10 countries. We found that 74% of the websites attributed depression to a chemical imbalance or claimed that the drugs could correct such an imbalance.[99]

Even in 2022, hospital-based psychiatry in one of the five regions in Denmark mentioned the chemical imbalance in relation to schizophrenia, depression, affective disorders, and AHDH on its homepage,[100] and the official website for health, sundhed.dk, mentioned it in relation to depression.[101]

The lies and the denial of the facts and psychiatry's own misdeeds are astounding. Whenever I have said in my lectures for psychiatrists that many patients have been told they have a chemical imbalance, I have been met with angry responses demanding that I document my allegations. When I referred to what patients, health professionals and others had told me, and to websites where patients have shared their experiences, I was told I didn't know what I was talking about, as if it didn't have any value to listen to people.

When I have argued that the documentation on the Internet is convincing because patients consistently have the same experiences, I was told these were just anecdotes which, moreover, had not been published in a peer-reviewed journal, as if that would make any difference. This is one of many indications that psychiatry is more of a religion than a science. Without a blessing from the psychiatric clergy, nothing counts.

In 2003, the deception became too much for six psychiatric survivors. They wrote to the American Psychiatric Association saying they would begin a hunger strike unless scientifically valid evidence was provided that major mental illnesses are biologically-based brain diseases and that any psychiatric drug can correct a chemical imbalance.[102]

The Association replied that, "The answers to your questions are widely available in the scientific literature." In his book, *The art of always being right*, philosopher Arthur Schopenhauer calls this deplorable trick "Postulate what has to be proven."[103]

The hunger strike ended when people started getting health problems. The Association stated that it would not "be distracted by those who would deny that serious mental disorders are real medical conditions that can be diagnosed accurately and treated effectively." To suddenly talk of something else, as though it had any bearing on the matter, is a classic Schopenhauer diversion. Religious leaders couldn't have invented a better bluff if people had required proof that God exists: "We will not be distracted by those who would deny that God exists and knows about people's problems and can treat them effectively."

Nothing changed. The textbooks did not use the term chemical imbalance directly, but many statements were made about drugs correcting what was claimed to be over- or underproduction of chemical messengers in the brain, which is the same thing.

A 2022 article demonstrated the extent to which the psychiatrists still propagate the lie about chemical imbalances.[104] All six influential US and UK textbooks published from 1990 to 2010 that the authors examined purport the hypothesis, at least in some sections, and devoted substantial coverage to it, and most of 30 highly cited reviews of the aetiology of depression supported it, as did most of 30 research papers on the serotonin system.

2 Depression

Depression pills are the most used psychiatric drugs. You will note that I do not use the term antidepressants, because they do not cure depression. In the USA, 13% of adults take them.[105] This is remarkable because people don't like them and would prefer psychotherapy.

What people get is not decided by what they want or what works, but by widespread institutional corruption.[106] Just before fluoxetine (Prozac) reached the market in 1988, the NIMH surveyed the public, and only 12% wanted to take a pill to treat depression.[107] This made the NIMH launch a public awareness campaign claiming a 45% difference in effect between the drug and placebo, whereas the US Food and Drug Administration (FDA) found only 10%.[108] Not even this small effect is correct (see below).

The NIHM also claimed that the pills lower mortality, whereas the truth is that they increase mortality.[109] These lies were immensely successful, and the media praised Prozac as the new wonder drug. However, it quickly became America's most complained-about drug, with hundreds of out-of-character suicides and homicides.[110]

In 1992, the UK Royal College of Psychiatrists and the Royal College of General Practitioners launched a five-year *Defeat depression campaign*,[111] which was also about teaching people the wonders of depression pills. But again, lay people saw it differently: In a survey, 91% thought that depressed people should be offered counselling; only 16% advised depression pills.

The psychiatrists' comment on this was that they needed to educate the public about depression drugs and tell them that dependence was not a problem. I fully understand why the survey also found that "the word psychiatrist carried connotations of stigma and even fear."

The main effect of depression pills is to ruin people's sex lives. Half of the patients who had a normal sex life before will have it disturbed or made impossible.[112] And yet, in the upside-down world of psychiatry, the pills that destroy your sex life are called happy pills. I called them unhappy pills in an article about our harmful happy pill epidemic.[113]

This harm can become permanent, and when the patients find out that they will never again be able to have sex, e.g. because of impotence, some kill themselves.[114] Rats can become permanently sexually impaired after having been exposed to SSRIs early in life,[115] which we confirmed in a systematic review of animal studies.[116]

We also tried to study the harms that persist in humans after SSRIs are stopped, but we could only include 12 trials. All the authors concluded that the drugs were not beneficial in the long term, but we could not quantify the drug harms.[117]

When I lectured for Australian doctors in 2015, a child psychiatrist said he knew three boys on depression pills who had attempted suicide because they couldn't get an erection the first time they tried to have sex. It is so cruel.

In most depression trials, the Hamilton Depression Rating Scale is used. It is so unspecific that even stimulants like cocaine, ecstasy, amphetamine, and other ADHD drugs could be considered depression drugs. Almost everything could. Many drugs that are not considered to be depression drugs show comparable effects to them, e.g. sleeping pills, opiates, stimulants, and some psychosis pills.[118]

Strange as it may sound, and despite their name, antidepressants don't work for depression. In flawed, industry-sponsored placebo-controlled trials the difference between drug

and placebo was only 2 on the Hamilton Scale,[119] and the smallest effect that can be perceived on this scale is 5–6.[120] This means the drugs don't work.

This clear message was not welcomed. Eskild Colding-Sørensen from the Danish Drug Agency claimed that a 2017 Danish meta-analysis[121] - the best ever done - bordered on irresponsibility. He forgot to say that he had a leading position in Lundbeck from 2010 to 2015.[122] The agency published a report concluding that the meta-analysis did not provide any new knowledge and that there was no reason to change recommendations or information about the drugs. This made us publish a newspaper article, *Does the Drug Agency work for patients?*[123] If there was no new knowledge, then why had the agency approved the drugs in the first place?

Colding-Sørensen headed the agency's investigation, and they did not consider it a problem that he had worked for Lundbeck because he had not worked with depression pills. We noted that this arrangement corresponds to authorities employing a leader from Volkswagen to investigate the scandal about fraudulent measurements of exhaustion gases from diesel oil, arguing that this wasn't a problem because he had worked with gasoline vehicles in the company. The agency's director, Thomas Senderovitz, who came from Grünenthal, the company that sold thalidomide, announced months before the investigation what the conclusion would be, as he said the meta-analysis concluded something the data could not sustain, which was totally false.

Other people also behaved as the industry's "useful idiots." The Minister of Health, Ellen Trane Nørby, urged the researchers to think carefully before they rushed into print with a message that could harm vulnerable people.

This led to a question in Parliament initiated by Stine Brix.[124] She asked the Minister to explain what she meant by "thinking carefully". Does it mean that "the Minister encourages researchers not to respond to inquiries from the press, or that, as a researcher, you should keep research results hidden from the public if they are controversial?"

The Minister disavowed herself. She now fully recognised "the right of researchers to express themselves about their research or anything else within the framework of our constitutional freedom of expression."

The chairman for the Danish Society for General Medicine, Anders Beich, opined that the researchers had published their results selectively, which was absurd, as they had done a systematic review of all trials. He also claimed there was no basis for the conclusions – a totally empty statement.[125]

The director of the Board of Health, Søren Brostrøm, talked about the lack of nuance, which had made patients worried. They surely should be worried if they took such drugs!

In an industry-funded magazine, psychiatrist Maj Vinberg characterised the meta-analysis as "a smear campaign against antidepressant drugs ... doubtful populistic discussions ... armchair gymnastics ... performed by a group of doctors, statisticians, and medical students without special knowledge about psychiatry and depressive disorders." Some of the authors were highly skilled and were my employees. I responded to Vinberg's ravings in the same magazine[126] alerting the readers to my article, *The meeting was sponsored by merchants of death*,[127] which included AstraZeneca, one of Vinberg's benefactors.

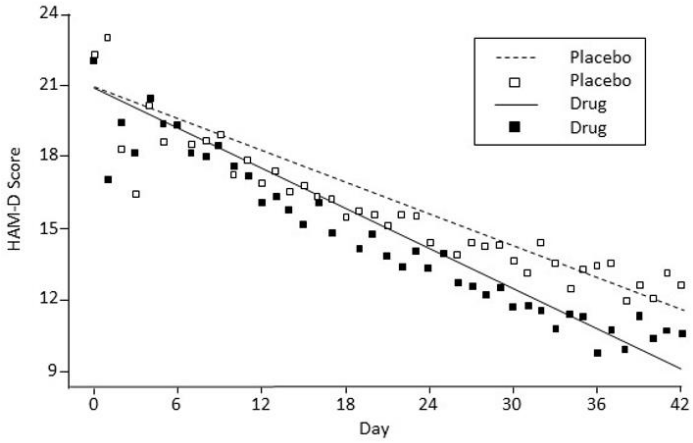
The small and irrelevant effect of the pills gets even smaller if the placebo is better blinded by containing atropine, which has similar side effects as the pills.[128] And the minimal clinically relevant effect is of course larger than the bare minimum of 5–6 that can be perceived. If you are being buried under a tonne of bricks, it doesn't help you much to take

one brick away, and your depression doesn't lift just because your psychiatrist has noticed a small change in a score.

Some meta-analyses have found that the effect is larger in severe depression, but the reported effects are also irrelevant for very severe depression, only 2.7.[129] Moreover, it is likely just a mathematical artefact that the effect seems to be slightly larger in severe depression.[130] Since the baseline scores are larger for severe than for mild depression, any bias will influence the measured result more in patients with severe depression.

It is difficult to get rid of this myth. In a 2023 letter calling for the UK government to commit to a reversal in the increasing use of depression drugs, the authors misleadingly said that "Multiple meta-analyses have shown antidepressants to have no clinically meaningful benefit beyond placebo for all patients but those with the most severe depression."[131]

Psychiatric textbooks are dishonest about the effect of depression pills, and I am not exaggerating; they truly are. One book claimed that you can notice an improvement on fluoxetine already after a few days.[132] However, whether the patients are treated with a pill or placebo, it takes about 3 weeks before anything can be noted (corresponding to the minimal clinically detectable effect of 5–6 on the Hamilton scale, see figure).[133]



Depression severity over time in 37 trials
of fluoxetine or venlafaxine versus placebo. Redrawn.

The textbooks mentioned huge effects, e.g. that 60–80% of the patients become healthy after 6–10 weeks but did not say that this is not a drug effect but the spontaneous remission of the depression. Moreover, telling patients it takes some weeks for depression drugs to work keeps them taking them even when they are not feeling better on the drugs but worse. By the time the weeks have passed, and they still feel bad, they may feel even worse if they try to stop the drug because they will get withdrawal symptoms.

This false information appears everywhere, also in a newspaper and in our medical journal, after I had said on TV that the drugs help 10–20% of the patients.[134] I was much too kind, as the drugs don't work at all, but my information was called "misleading" and the TV programme was criticised for having talked to me and not to a psychiatrist.

I explained in 2011 how dishonest the psychiatrists are:[135] "In *Weekendavisen* on 15 April, Poul Videbech, Raben Rosenberg and Lars Kessing criticise DR (Danish Radio) for having mentioned that the effect of SSRIs is 20%. They even call it misinformation, but the criticism is unjustified. Firstly, DR has replied that the information comes from the Danish

Medicines Agency. Secondly, the psychiatrists themselves write that the difference between placebo and active substance is precisely 20%."

The psychiatrists arrive at their high numbers by disregarding the improvement in the placebo group. But, as a general practitioner noted, this shows they cannot interpret the evidence.[136] Using their way of thinking, one could argue that drugs can cure 100% of patients with a common cold.

In 2011, Videbech noted that he had received money from virtually all drug companies in Denmark, but when a journalist asked him about a handbook for patients with depression that he had written for a website sponsored by Eli Lilly, he got so angry that he hung up.[137]

When psychiatrists – rarely – acknowledge that the effect of the pills is small, they often add that it is not important because the patients will benefit from the large placebo effect. This is a common misconception. Doctors often think the placebo effect is the before-after difference in a group of patients treated with a placebo, which it isn't, as the spontaneous improvement is included. Placebo effects are small, if any.[138]

One textbook claimed that psychomotor speed, sleeping pattern, appetite, and mood become normalised, and that depressive thoughts about guilt, inferiority, and suicide vanish. Absolutely nothing becomes normal because of pill treatment.

When I mentioned on TV in 2011 that depression pills can change a patient's personality, Jeanett Bauer, the president of the Danish Psychiatric Association, and another psychiatrist, Jesper Karle, replied that it was misleading to focus on a side effect that is so scary for patients and extremely rare.[139]

It is not rare, and I criticised Bauer and Karle also for their misleading information about the drugs. They claimed they worked for two-thirds of the patients and that the side effects were mild and transient.[140] Six years earlier, Danish psychiatrists reported that half of the patients agreed that the treatment could alter their personality and that they had less control over their thoughts and feelings.[141] The psychiatrists refused flatly to believe what the patients had told them, called them ignorant, and felt they needed "psychoeducation." However, the patients' relatives had the same opinion as the patients.

These pills have turned an episodic disorder into a chronic one. The American Psychiatric Association's Textbook of Psychiatry from 1999 stated that, earlier, most patients would recover from a major depressive episode, whereas now "depression is a highly recurrent and pernicious disorder."[142] There are none so blind as those who will not see. In a study of 172 patients with recurrent depression who had been in remission for at least 10 weeks,[143] 60% of those who continued to take drugs relapsed in two years whereas only 8% of those who did not take drugs and received psychotherapy relapsed. Differences in disease severity could not explain these results.

Brain scan studies play a major role when psychiatrists try to convince people that their drugs are necessary. The textbooks are full of extraordinary claims about what depression pills can accomplish in the brain.[144] But there are no references, and what is claimed is highly unlikely to be true, e.g. that the pills stimulate nerve cell growth, decrease brain damage, are neuroprotective, and prevent nerve cell death.

Brain imaging studies are grossly unreliable.[145] In 2022, neuroscientists commented on the neuro-imaging studies published during the last 30 years and concluded that, "we still lack a neurobiological account for any psychiatric condition … functional neuroimaging plays no role in clinical decision making."[146]

Moreover, considering that depression pills have no clinically relevant effects on depression and are harmful (see more below), it is immaterial what imaging studies show or don't show.

Videbech claimed in 2014 that his and others' studies had shown that untreated depression led to atrophy in the hippocampus and frontal lobes, and that studies had shown that antidepressants could reverse these changes, both in animals and humans.[147]

He also believes that depression doubles the risk of dementia,[148] and in *The British Medical Journal* (*BMJ*), I disputed another claim that was made, without references, that depression and anxiety are risk factors for Alzheimer's disease.[149] However, the meta-analysis Videbech cited did not mention one word about which treatments the patients had received.[150] Other studies indicate that it is the drugs that make people demented.[151] A PhD holder in psychopharmacology, Jesper Andreasen, however, also believes it is the disease that makes people demented. He criticised me for not being a psychiatrist or an expert on psychiatric drugs.[152] Well, I have learned to read and understand what I read, which Andreasen hasn't because he believes psychiatric disorders are caused by chemical imbalances.

Since depression pills have only small symptomatic effects and many harms, it is relevant to find out what the patients think about them when they weigh the benefits against the harms. They do this when deciding whether to continue in a trial till the end or to drop out.

It was laborious to do a study on this. We included 71 clinical study reports (18,426 patients) we had obtained from drug regulators. No one outside my research group had read the 67,319 pages about these trials before; they amounted to a stack 7m high.

We found that 12% more patients dropped out while on drug than while on placebo.[153] This is a very important result. The psychiatrists' view is that depression pills do more good than harm, but the patients' view is the opposite. They preferred the placebo even though some of them had been harmed by cold turkey withdrawal effects when being randomised from a drug they were already on to a placebo. That means that the drugs are even worse than what we found.

We also looked at quality of life, which we expected would be worse on pills than on placebo. But now we had come too close to the secrets of depression pills. The reporting of quality of life was virtually non-existent.[154] A huge amount of data was missing in the clinical study reports, and selective reporting of outcomes that happened to be positive was common. Despite this bias, we found only small differences between drug and placebo.

We wondered why the drug regulators had not asked the companies for the missing data, as was their duty. Considering the gigantic coverup, the result for the drop-out rate, and all the common drug harms, I have no doubt that the pills worsen quality of life.

In 2017, Stine Brix asked the Minister of Health if it was a reliable conclusion when the Danish Drug Agency emphasised that in some of the studies an effect on quality of life had been found, when only three out of 131 studies had published data on quality of life.[155] In her reply, the minister referred to the drug agency that said that there was an effect on quality of life in the studies where this was measured. This was ultra-comical. Quality of life was measured in many more studies than those that reported what they found!

The textbooks recommended dose increases to obtain better effects and one noted that escitalopram was a possible exception to the fact that a dose-response relationship is poorly elucidated for SSRIs. The FDA package insert for escitalopram directly contradicts this:

"Initial: 10 mg once daily. Recommended: 10 mg once daily. Maximum: 20 mg once daily … No additional benefits seen at 20 mg/day dose."[156]

The truth is that there are many dose-response studies of depression pills and they have not shown an increased effect with larger doses.[157] What doctors obtain by increasing the dose is to waste taxpayers' money and to increase the risk of killing their patients.[158]

For fluoxetine, receptor occupancy is very similar for 20 mg, 40 mg, and 60 mg.[159] Nonetheless, the UK drug regulator advises doctors to double or triple the dose if the response is insufficient.[160] This advice can be lethal. More deaths for no gain in effect. It is horrendous that a drug regulator, which is supposed to issue instructions based on solid science, says that "it is clinical experience that up-titrating the dose might be beneficial for some patients." Psychiatrists value their clinical experience without realising how misleading it might be, but drug regulators should not support them in this illusion.

The dream of a quick fix for depression never stops. The latest fad is esketamine, the S-enantiomer or mirror image of ketamine, a dissociative hallucinogen used as a general anaesthetic for over 50 years. In 2019, two psychiatrists praised esketamine for treatment resistant depression in the *BMJ*.[161] I responded with some colleagues that a drug cannot possibly have a dramatic effect on depression within the first day of treatment unless something is terribly wrong.[162]

Psychiatry is a surreal world. Despite all the warnings and deaths, Lykos Pharmaceuticals is trying to get ecstasy – a psychedelic - approved for treatment of post-traumatic stress disorder (PTSD). In June 2024, FDA's advisory panel declined to recommend the approval of it, and they said the studies were marred by inconsistencies, poor study design and allegations of misconduct.[163] Time will show if there is any sanity at the FDA. Psychedelics should not be used in psychiatry, but with my knowledge of the FDA, I find it likely they will approve the drug.

Psychiatry repeats history and makes the same mistakes over and over, as there isn't really anything new. It has become popular again to recommend other hallucinogens, e.g. psilocybin, produced by fungi, and even LSD (lysergic acid diethylamide) is being dusted off. In 2020, the authors of a systematic review reported positive results and concluded that LSD is "a potential therapeutic agent in psychiatry."[164] Psychiatry is a perpetuum mobile of mistakes.

It can be useful to know how many patients you need to treat to benefit one of them. Psychiatrists often refer to this when they claim their drugs are very effective, but the number needed to treat (NNT) with a psychiatric drug to benefit one patient is largely an illusion.[165] The most important reason is that more patients are harmed than those who benefit.

Harms and benefits are rarely measured on the same scale, but when patients in a placebo-controlled trial decide whether it is worthwhile to continue in the trial, they make a judgement about if the benefits they perceive exceed the harms. As already noted, we found that 12% more patients dropped out on a depression pill than on placebo, which translates into a number needed to harm (NNH) of 25.[166]

In psychiatry, NNT is so misleading that it should be abandoned. We might instead use NNH. Since depression pills harm the sex life in half the patients,[167] the NNH is only two. Thus, by *not* using depression pills, we will preserve the normal sex life in one out of every two patients we do *not* treat.

What I have just outlined about NNT being an illusion, applies to all psychiatric drugs.

Exercise works for depression. In a large trial of 156 patients, only 30% of the patients in the exercise group were depressed, as compared with 52% in the sertraline group, six months after the four-month intervention period.[168] And a 2024 systematic review found that the effects were proportional to the intensity of the exercise, with substantial effects on depression of walking or jogging (effect size 0.62), yoga (0.55), strength training (0.49), mixed aerobic exercises (0.43), and tai chi or qigong (0.42).[169]

Rewarding the companies that cheated the most

A 2018 network meta-analysis in *The Lancet* by Cipriani and colleagues[170] got enormous attention in the media even though the drug effect was the same as in earlier meta-analyses.[171] As we noted, there was nothing new, but the researchers called for antidepressants to be more widely prescribed.[172]

The meta-analysis ignored entirely the data on harms, and it was so flawed that I wrote the article, *Rewarding the companies that cheated the most in antidepressant trials*.[173]

The authors included 522 trials that compared the drugs with each other or with placebo, and most of the data came from published reports. They ranked the drugs according to their effect, which was absurd as none of them are effective, and drop-out for any reason. They claimed that agomelatine, escitalopram, and vortioxetine were both more effective than other drugs and also better tolerated. As this is extremely unlikely, I took a closer look at the three drugs.

Astonishingly, a review of agomelatine - which Cipriani co-authored - found no effect on the Hamilton scale even though none of the negative trials had been published.[174] So, we are supposed to believe that an ineffective drug is more effective than other ineffective drugs. In the magic world of psychiatry everything is possible ...

It is also far-fetched to believe that escitalopram can be better than citalopram. The active ingredient is the same as in citalopram, which is a stereoisomer. Stereoisomers consist of two halves, which are mirror images of each other, but only one of them is active. When studied by Lundbeck in head-to-head trials, and meta-analysed under Lundbeck's control, the active molecule is better than itself.[175] All three authors worked for Forest, Lundbeck's American partner, and the paper was published in a bought supplement to a journal edited by the first author of the paper.

Four independent reviews, including by the FDA, concluded that escitalopram is not better than its mother molecule.[176] Independent researchers found that the efficacy appeared to be better for escitalopram than citalopram in head-to-head trials, but when they did an indirect comparison of the two drugs based on 10 citalopram and 12 escitalopram placebo-controlled trials, the efficacy was the same.[177] The drug industry distorts its research to such an extent that indirect comparisons are sometimes the most reliable ones.

Lundbeck launched escitalopram when the patent for citalopram expired and earned a lot of money from it via a huge fraud scheme that involved kickbacks and where the positive outcomes of the trials were already written before the trials were begun![178]

When I checked the prices in 2009, the rejuvenated "me-again" drug cost 19 times as much for a daily dose as the original drug. This enormous price difference should have deterred doctors from using escitalopram, but it didn't. It sold for six times as much than the mother drug. If all patients had received the cheapest citalopram instead of escitalopram or other SSRIs, Danish taxpayers could have saved around €30 million a year, or 87% of the total amount spent on SSRIs.

The Cochrane review of escitalopram, which has Cipriani as first author, is disgraceful. It claims that escitalopram is significantly more effective than citalopram.[179] Cochrane rewards the companies that cheat the most.

The official task of the government-funded Institute for Rational Drug Therapy is to inform Danish doctors about drugs in an evidence-based fashion. In 2002, the Institute noted that escitalopram didn't have clear advantages over its mother drug.[180] Lundbeck complained loudly in the press and said it was beyond the Institute's competence to give statements that could damage Danish drug exports.[181] It wasn't, but the Institute was reprimanded by the Minister of Health, Lars Løkke Rasmussen. Our highly praised Institute was only allowed to tell the truth about imported drugs, not about drugs we export.

Two years later, the Institute announced that escitalopram was better than citalopram.[182] I had a big laugh when I saw the four references in support of the positive statements.[183] I laughed again when an employee from the Institute, Karin Friis Bach, was interviewed on TV. The journalist asked her if she couldn't imagine any situation where it might be an advantage that the drug worked faster. She replied: "Yes, if a patient is about to throw herself out the window!" This was doubly ironic, as SSRIs double the risk of suicide (see below).

In 2003, Lundbeck breached the UK industry code by advertising that Cipralex (escitalopram) is significantly more effective than Cipramil (citalopram).[184] Lundbeck also attributed harms to citalopram in its literature on escitalopram that weren't mentioned in its promotional material for citalopram. It is surprising how quickly a good drug becomes a bad drug when the patent expires.

The European Commission imposed huge fines on Lundbeck and on producers of generic citalopram that, in return for cash, had agreed with Lundbeck to delay market entry of generic citalopram in violation of EU antitrust rules.[185] Lundbeck had also purchased generics' stock for the sole purpose of destroying it.

Vortioxetine seems to be an exceptionally poor drug. Every author of the short-term trials had commercial ties to Lundbeck, but independent researchers found that duloxetine and venlafaxine were significantly more effective than vortioxetine at three of the four dose levels tested.[186] Pretty "interesting," given that none of the depression drugs have clinically relevant effects.

Cipriani hyped his network meta-analysis to the extreme, e.g. in *BBC News*,[187] where he and the Royal College of Psychiatrists called it the final answer to the long-standing controversy about whether the pills work for depression. There were "big differences in how effective each drug is" (none of them are effective), and "at least one million more people in the UK would benefit."

Cipriani's paper was hyped to the extreme on the homepage of one of the Danish regions, which highlighted Lundbeck's expensive me-again drug, Cipralex.[188] Videbech - a national icon for depression - starred as one of Lundbeck's useful idiots, saying that Cipriani's meta-analysis was "far more credible" than the Danish meta-analysis published a year earlier. He even claimed that Cipriani had considered the sources of error that the Danish researchers had not been aware of.

As so often before, which is also clear in the textbook he edited,[189] Videbech was highly manipulative.

First, Cipriani's review was of very poor quality while the Danish review was exemplary and rigorous. This is odd, because two of Cipriani's co-authors are researchers with whom I have published guidelines for good reporting of network meta-analyses,[190] and a third author is

statistician Julian Higgins, editor of the Cochrane Handbook of Systematic Reviews of Interventions that describes in 659 pages how do to Cochrane reviews.

Second, contrary to what Videbech said, the Danes *did* find a significant drug effect but noted that "all trials were at high risk of bias and the clinical significance seems questionable."

Third, there were no errors in the Danish review, and Videbech and Cipriani had not noted any. Cipriani did not cite the Danish review although it was published 12 months before his own.

Fourth, Cipriani's review was *far less* credible than the Danish review, which only included comparisons with placebo. As noted for escitalopram, head-to-head comparisons of drugs are notoriously unreliable.[191] Another example: Significantly more patients improved on fluoxetine when fluoxetine was the drug of interest than in trials where fluoxetine was the comparator drug.[192] Oddly, as Cipriani co-authored this study, he *knew* that what he published in *The Lancet* was untrustworthy.

Fifth, the effect size in the Danish review was about the same as in Cipriani's review, 0.26 versus 0.30.

The main difference was how the researchers interpreted their results. The Danes concluded that "The potential small beneficial effects seem to be outweighed by harmful effects." Cipriani concluded: "All antidepressants were more efficacious than placebo," with no caveats about the risk of bias even though they said they "assessed the studies' risk of bias" in accordance with the Cochrane Handbook.

My research group showed that the outcome data in Cipriani's review differed from the clinical study reports in 63% of the trials; that the effect of the drugs was higher in published than in unpublished trials; and confirmed that there was a high risk of bias in the trials.[193] When their paper was accepted for publication, the editor wrote to Cipriani asking him to respond. He didn't find it necessary to defend his research, or, more likely, he abstained because he couldn't defend it.

The absurdity of it all can be seen by comparing two articles in *The Guardian*. Prozac did not work in 2008 (effect size 0.32),[194] but ten years later, *all* drugs worked (effect size 0.30).

The Guardian 26th Feb 2008

Prozac, used by 40m people, does not work say scientists

Analysis of unseen trials and other data concludes it is no better than placebo

Full text: the PLoS paper

Prozac, the bestselling antidepressant taken by 40 million people worldwide, does not work and nor do similar drugs in the same class, according to a major review released today.

The Guardian 21st Feb 2018

The drugs do work: antidepressants are effective, study shows

Doctors hope study will put to rest doubts about the medicine, and help to address global under-treatment of depression

It's official: antidepressants are not snake oil or a conspiracy

Antidepressants work - some more effectively than others - in treating depression, according to authors of a groundbreaking study which doctors hope will finally put to rest doubts about the controversial medicine.

This whole affair was hugely embarrassing for Cipriani *et al*., Cochrane, *The Lancet*, and Videbech. Virtually all Cochrane reviews and another network meta-analysis Cipriani did, of depression drugs in children and adolescents,[195] should also be distrusted. This is clear if we

compare the results obtained in these reviews with the data in the clinical study reports the drug companies have submitted to drug regulators, which are far more trustworthy.[196]

Danish psychiatrist Ole Bjørn Skausig contributed to the absurdity when he published a comment in our medical journal in 2011 with the headline: *Should one prescribe the best or the cheapest?*[197] He argued that, "Internationally, escitalopram is recognised as clearly the best SSRI ... experience also counts ... meta-analyses are often of little use, even if they are currently in vogue." He advised that one should double or triple the dose; said it is cheaper for society if the patients become cured; and noted that he often used antiepileptics, lithium, and atypical antipsychotics for patients with depression.

It is rare that people so clearly admit how dumb they are. Escitalopram is not better than other depression drugs; clinical experience is highly misleading; meta-analyses of randomised trials is the most reliable evidence we have; drugs that don't work, don't work any better if you triple the dose, which will increase the risk of dying; no drug can cure depression; and you will learn below that depression should be treated with psychotherapy, not with toxic drugs. Skausig denied that the drug companies had hidden suicidal events on their depression drugs and claimed I had misled the public when I said so. He did not tell his readers that he is a psychiatrist and had received honoraria from Lundbeck and Novartis.[198]

The STAR*D study, a NIHM $35 million fraud

STAR*D, a huge trial financed by the NIMH at a cost of $35 million, is a remarkable story of fraud.[199] It was a study of "real-world patients," and with 4,041 included patients, it was the largest effectiveness study ever conducted of depression pills. I wonder what the investigators used the huge grant for, and as it was a simple, pragmatic study, it could have been done at virtually no cost.

The investigators announced boldly that the study would produce results with "substantial public health and scientific significance."[200] It surely did, but not in the way they had imagined.

There was no placebo group. All patients started on citalopram, manufactured by Lundbeck. This was motivated by the erroneous claims that citalopram did not have any discontinuation symptoms and that it was safe to use in elderly patients. A more plausible reason is corruption: Ten of STAR*D's authors reported receiving money from Forest, Lundbeck's American partner.

When the study was over, NIMH announced that "about 70% of those who did not withdraw from the study became symptom-free." The investigators also made numerous false claims, e.g. that the remitted patients had "complete absence of depressive symptoms" and had "become symptom-free." However, a "remitted" patient could have a Hamilton score of 7. The only Hamilton suicide question, "feels like life is not worth living," is scored as 1, and other symptoms scored as 1 include "feels he/she has let people down" and "feels incapable, listless, less efficient." No honest professional would describe such patients as being symptom-free.

The researchers noted in their abstract that, "The overall cumulative remission rate was 67%." However, in the main text, they admitted that this was a "theoretical" remission rate assuming that those who exited the study had the same remission rates as other patients. This is false, and numerous studies have shown that there are more treatment failures among those who drop out than among those who continue.

The investigators cherry-picked the data they used. And they changed the measurement scale, which we call the Texas sharpshooter fraud. You fire a gun towards a target but miss it. Next, you wipe out your target and draw a new one around your bullet hole and present this to the public. They also included patients that should have been excluded according to the protocol.

The presentation of the data was confusing. It is extremely difficult to find out what happened and to correct all the errors. Fortunately, Ed Pigott *et al.* did the hard work. It turned out that only 3% of the patients who entered the trial remitted, stayed well, and stayed in the trial during the one-year follow-up.[201] When a journalist interviewed one of the investigators, Maurizio Fava, he acknowledged that the 3% success rate was accurate and that the investigators knew this all along.[202]

The investigators bombarded doctors and the public with the mendacious message that depression pills enable 70% of the patients to recover. The drugs were "far more effective" than placebo, which is a ridiculous statement as there was no placebo group in the study, and whatever the true recovery rate, it was mainly due to spontaneous remission.

The many STAR*D papers - over 100 by 2011 - display highly selective reporting of outcomes, numerous false claims, contradictory statements, and even pure fiction. Also, 11 prespecified outcomes had still not been reported.[203] The abstract in one paper stated that suicidal ideation was seen in only 0.7% of the patients, which caused the authors to dismiss concerns about suicidality caused by the drugs. However, some of the same authors stated a ten times higher suicidality rate in other papers. Psychiatry is full of surprises …

Ed Pigott says that all the errors he identified during his more than five years of research had the effect of making the effectiveness of the drugs look better than they were.[204]

The STAR*D study is so fraudulent that all the publications should be retracted.[205] But when Bob Whitaker wrote to Ned Kalin, the editor of the *American Journal of Psychiatry*, notifying him of a petition signed by over 1,800 people calling for retraction of the first fraudulent article,[206] Kalin did not even reply.[207] Instead, some of the STAR*D investigators doubled down on the fraud in the journal, without mentioning the petition. They were so arrogant that they lied, accusing Pigott's analyses of being flawed and based on post-hoc criteria, although Pigott used their own protocol.

So, the response by the journal was to publish even more lies. The owner, the American Psychiatric Association, did nothing either. As Bob explains, this demonstrates that deliberate research fraud in this domain of medicine is acceptable practice, which in this case has done extraordinary harm.[208] The STAR*D study is still highly cited in psychiatric textbooks and elsewhere,[209] and its fraudulent results are not questioned.

Mainstream media have failed their journalistic obligations. American newspapers have remained mute, even though Pigott and colleagues have contacted reporters at *The New York Times* and other major newspapers, urging them to set the record straight.[210] The *Times* has been repeatedly urged to write about this scandal, but the paper has not only refused – it even published the false claim of 70% effect again in a 2024 article that praised the drugs.[211] Pigott *et al.* showed that if the STAR*D investigators had adhered to their protocol, they would have reported a remission rate of only half as much, that is, 35%.

Why did the *Times* repeat the fraud and praise drugs that don't work and cause suicide? Did the *Times* sink "to a new low in its psychiatric drug coverage" because it is desperate not to lose advertising income?[212]

Cochrane review of depression pills in children: dangerous garbage

A 2021 Cochrane review of depression pills in children[213] demonstrates the saying, "garbage in, garbage out."[214]

The very title shows that Cochrane is too beholden to industry: *New generation anti-depressants for depression in children and adolescents: a network meta-analysis*. New generation (or second or third generation) drugs are marketing terms whose aim is to give readers the impression that these drugs are better than old drugs. The terms have no relevance or meaning. The first author is Sarah Hetrick, editor in the Cochrane Mental Disorders group that published the review; she should have known better.

The abstract is full of nonsense. It says that "There is an association between major depressive disorder and suicidal ideation, suicide attempts, and suicide. Antidepressant medication is used in moderate to severe depression." This gives the readers the impression that the pills protect against suicide. The abstract should have warned that the pills can *cause* suicide.

We are told that "The evidence is very uncertain" for suicide-related outcomes for six named drugs. This information is misleading and dangerous. We have known for 20 years that depression pills increase the suicide risk in children and adolescents (see below). The Cochrane authors miss the forest by looking at one tree at a time, and it gets worse:

"There is low certainty evidence that escitalopram may 'at least slightly' reduce odds of suicide-related outcomes compared with placebo (OR 0.89, 95% CI 0.43, 1.84)." The confidence interval goes from 0.43 to 1.84. This is not evidence that the drug reduces the suicide risk. The confidence interval includes the possibility that escitalopram doubles the suicide risk, which is exactly what it does.

Similarly, to say that four named drugs may "at least slightly" increase odds of suicide-related outcomes is dangerous nonsense that downgrades this harm. And "slightly" is a subjective term that does not belong in a scientific paper. People will not agree about what "slightly" means, and when does it stop being slightly and becomes moderately or substantially?

The nonsense continues in the abstract. "There is moderate certainty evidence" (what is that?) that venlafaxine "probably" results in an "at least slightly" increased odds of suicide-related outcomes compared with desvenlafaxine. In this case, the difference was statistically significant, so why talk about "probably" and "at least slightly?" The main problem is that desvenlafaxine is the "me-again" product of the mother molecule, venlafaxine, which is a stereoisomer. What is the likelihood that a drug can be better than itself? Cochrane didn't bother but behaved as the mouthpiece of Pfizer, the manufacturer.

The Cochrane authors should have learned from the devastating criticisms that were raised against Cipriani's review, but they didn't learn anything.

I had access to Eli Lilly's clinical study reports and therefore knew that Graham Emslie had omitted two suicide attempts among 48 children on fluoxetine in the publication of his first trial of fluoxetine.[215] I tried to find out if Hetrick *et al.* had included these two events in their meta-analysis, but it was impossible. Some of the text was gobbledegook: "Additional data were sought and supplied by the authors. Data in the MA for child, adolescent and total populations taken from paper publication and these additional data Child and adolescent data from author. MHRA # X065 MHRA contacted for additional data some of which was provided."

After having read the abstract, I realised it would be a waste of time to read all the 225 pages in the review, which could have been written in five pages. The evidence clearly shows that these drugs should not be used in children or adolescents. But the authors' conclusions were absurd:

"Our findings reflect the average effects of the antidepressants, and given depression is a heterogeneous condition, some individuals may experience a greater response. Guideline developers and others making recommendations might therefore consider whether a recommendation for the use of newer generation antidepressants is warranted for some individuals in some circumstances."

The authors apparently don't know what statistical variation is. We use average effects to draw conclusions, but the authors presented wishful thinking and behaved as the drug industry's useful idiots. Their argument can be used about all ineffective treatments, also bogus treatments like homoeopathy. Some individuals may experience a greater response than others, right? This is Cochrane at its worst.

Driving children to suicide with happy pills

Nothing illustrates the lethal power of drug marketing, corruption of doctors, and fraud better than the fact that it has been possible to convince doctors to prescribe depression drugs to children even though they don't work for them and double their risk of suicide (see below).

The drug companies' fraud is grave. They have hidden suicides and suicide attempts in their trials, or they have added them to the placebo arm, although they didn't belong there.[216]

The FDA is complicit in this fraud. When they analysed the suicide risk in 2006, for all ages,[217] they asked the companies to send suicide-related adverse events to them knowing perfectly well they couldn't be trusted. Earlier, when FDA reviewers and independent researchers had found that the drug companies had concealed cases of suicidal thoughts and acts by labelling them "emotional lability," the FDA bosses suppressed this information.[218] When FDA's safety officer Andrew Mosholder concluded that SSRIs increase the suicide risk among teenagers, the FDA prevented him from presenting his findings at an advisory meeting and suppressed his report. When the report was leaked, the FDA's reaction was to do a criminal investigation into the leak.[219]

As the companies knew the FDA wouldn't check their work, it was easy for them to cheat also on this occasion. I have shown that, in trials of some drugs, there were more suicides than in the whole FDA analysis of all the drugs.[220]

Thomas Laughren was responsible for FDA's 2006 meta-analysis. He published a paper five years earlier using FDA data where he reported 10 times as many suicides per 10,000 patients randomised to depression pills[221] than in his 2006 analysis. It is amazing that it can be so subjective if someone died or not but remember: This is psychiatry.

The FDA reported in 2006 that depression pills double the risk of suicide, suicide attempts, or preparation for suicide in people under 25 years of age.[222] The suicidal event rate was shockingly high: 2 out of 100 young people experienced this during a few weeks of treatment. Many children, who didn't suffer from any psychiatric disorder, have killed themselves because of the unbearable harms of the drugs, which they didn't recognise, as they thought they had gone mad.[223]

The drug companies knew how dangerous their drugs were before they marketed them. Eli Lilly knew that fluoxetine could cause a strange, agitated state of mind with unbearable rage, delusions, and disassociation, or an unstoppable urge to commit suicide or murder.[224]

Suicide, violence, and homicide on depression pills and other psychiatric drugs are strongly associated with akathisia,[225] which is a state of extreme restlessness and inner turmoil. It literally means you can't sit still. You may have the urge to tap your fingers, fidget, jiggle your legs, or endlessly pace up and down. Akathisia need not be visible, but it can cause inner torment with extreme anxiety.

Although akathisia is one of the most dangerous symptoms that exist, psychiatrists often overlook or dismiss it. One textbook called key symptoms of akathisia "agitated depression."[226]

In 2011, Lundbeck's director, Ulf Wiinberg, claimed in a Danish radio programme that depression drugs reduce suicides in children. At the same time, Lundbeck's US partner Forest was negotiating compensation with 54 families whose children had committed or attempted suicide while taking Lundbeck's depression pills.

The journalist and the invited expert from the Danish Drug Agency were stunned, and I published an open letter to Lundbeck on a science site.[227] Lundbeck's research director, physician Anders Gersel Pedersen, responded in a highly condescending way:[228]

"We have – with regret – read Peter Gøtzsche's open letter, which unfortunately seems characterised by a limited professional insight into the complicated and extremely important issue of suicide and suicidal behaviour associated with depression in children and adolescents, and a possibly increased suicide risk in relation to treatment of depression with antidepressants ... In our view, any dialogue on this important topic should be evidence-based and not just take the form of superficial polemic on an insufficient basis."

Pedersen's article tells us a lot about how people in drug companies think. For research directors in drug companies, science is just window dressing. I have explained at length[229] why his seven references are misleading.

Pedersen argued that that there is no clear relationship between suicidal behaviour, suicide attempts and suicide. This is not correct. People who display suicidal behaviour are at much greater risk of suicide than people who don't.

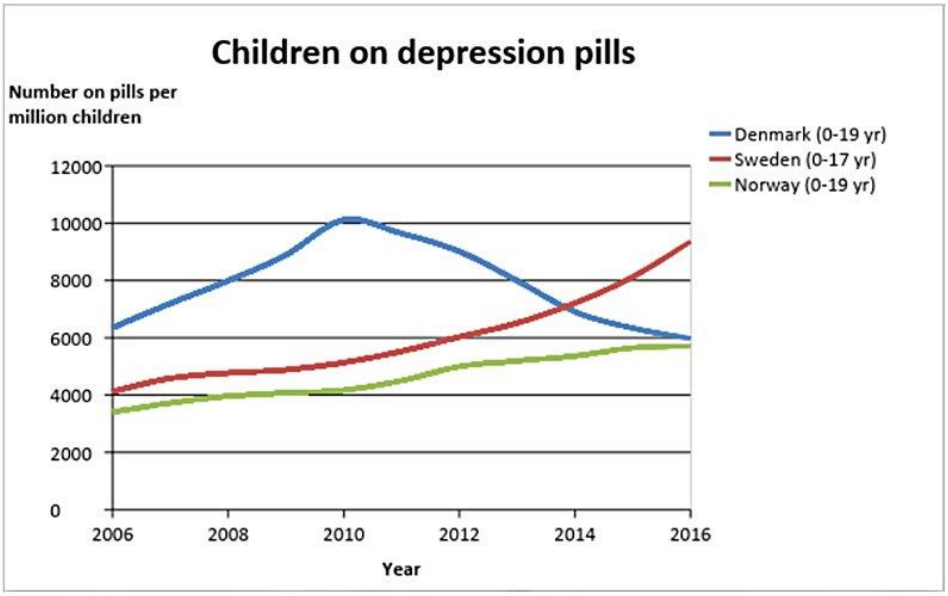
Pedersen quoted a study of suicides in Danish children[230] by Kessing who was on the Lundbeck payroll. Suicides were 19 times more common when the children had been treated with an SSRI. The study was funded by The Lundbeck Foundation and the result wasn't good for Lundbeck. The authors presented another analysis where they had corrected for psychiatric hospital contact. The risk was still increased, 4.5 times, but "no longer quite significant." It is wrong to correct for psychiatric hospital contact, which increases the suicide risk for psychiatric patients 44 times.[231] A correction for a factor in the causal chain will spuriously attenuate or remove a true relationship.

Kessing found that SSRIs dramatically increase the risk of suicide in children but concluded the opposite: "Not treating severely depressed children and adolescents with SSRIs may be inappropriate or even fatal."

What is fatal is that we have psychiatric professors like Kessing and Videbech who have cited this study uncritically many times as "evidence" that depression drugs do not cause suicide, e.g. in *Politiken* in 2020.[232] To be sure no one would miss the point, Videbech used a declarative title, "No, Peter Gøtzsche: Medication for depression is not crazy. It is actually extremely useful." Videbech claimed that it is "evident that without clinical experience it is

impossible to meaningfully interpret the results of various studies." This is plain nonsense. I would say that, without a rudimentary knowledge of research methodology, it is impossible to meaningfully interpret the results of various studies. Videbech is in that position.

Lundbeck's horrendous lie made me begin to warn strongly against the suicide risk of the pills, on radio and TV, and in articles, books, and lectures. In 2011, the Danish Board of Health reminded family doctors that they should not write prescriptions for depression pills for children, which was a task for psychiatrists. As they had done this before, to little effect, I am convinced that the huge drop in usage we saw was due to my tenacity (see figure).[233]



Even though professors of psychiatry in all three countries continued to propagate the lie that depression pills protect children against suicide, the number of children in treatment decreased by 41% in Denmark while it increased by 40% in Norway and 82% in Sweden.

Considering all ages, the consumption of depression pills increased by 37% between 2010 and 2020 in 24 European countries.[234] Denmark was the only country where usage dropped (by 4%).

In 2013, I debated with Kessing on TV in the Evening Show about suicides caused by depression pills. I have uploaded the debate,[235] and bits of it appear in the film, *Diagnosing Psychiatry*.[236] Kessing denied the science and the drug agencies' warnings totally, saying that we know with great certainty that SSRIs *protect* against suicide. He added that the risk of suicide is large when people stop SSRIs but failed to mention that this is because of the pills' harmful withdrawal effects when the patients stop cold turkey.

Shortly afterwards, Kessing accused me of being unprofessional and campaigning against antidepressants, claiming that there isn't a single study in the world that has shown that they increase the risk of "completed suicide."[237] I replied that his erroneous statements hardly increased the confidence in the specialty's professors and that another professor, Videbech, agreed with me in a debate we had on radio and TV two weeks earlier that SSRIs can cause suicide.[238]

Three days later, I was in another TV debate with Kessing, this time about how we could reduce the consumption of depression pills. Kessing claimed they are not dangerous. Lund-

beck's research director, Anders Gersel Pedersen, said that what is most dangerous is *not* to treat the patients, and he claimed they don't become addicted but get a relapse when they stop taking the pills. Kessing claimed that only 10% of those who visit their family doctor aren't helped - quite a remark about drugs that don't work!

When the interviewer asked Kessing how the consumption of pills could be reduced, he didn't answer the question. He said we knew for sure that there had been a rising incidence of moderate to severe depression over the past 50 years. This is not true.[239] I explained that the criteria for diagnosing depression had been substantially lowered during these 50 years, and that the prevalence of severe depression has not increased. Most patients who get a diagnosis of depression live depressing lives, e.g. are married to the wrong person, have a bullying boss, a tedious job, no job, or a chronic disease. It is not the task of doctors to try to get them out of this predicament, and a pill won't help. A doctor who saw a depressed unemployed person and suggested medication, got this indignant reply, "I don't need medication; I need a job."[240] Unemployment, poverty, trauma, and other psychosocial factors are major risk factors for depression.[241]

I have been continually harassed by professors of psychiatry.[242] Kessing opined in 2016 that our meta-analyses documenting the suicide risk were unusually unscientific and published in journals of little scientific standing. I see. Using the best available methods and publishing in journals of high repute, such as the *BMJ*, *Journal of the Royal Society of Medicine*, and *Canadian Medical Association Journal*,[243] apparently equals poor science.

Raben Rosenberg's ravings about me included "a shrill tone with highly subjective interpretations," "monomaniacal and know-all form that reflects a contempt for the psychiatric profession," "ideological crusade, which is ethically deeply problematic," and "anti-psychiatric campaigns, the background of which is the gross simplification principle."

If you have no arguments, it seems you raise your voice, or talk nonsense, or both.

In Sweden, things were also bad. In 2017, the leaders from the Board of Health and the Drug Agency and four "experts" wrote in the *Swedish Medical Journal* that fluoxetine should sometimes be used in young people: "There is no evidence that treatment with antidepressants increases the risk of suicide. Rather, the evidence points in the opposite direction." Can it be worse than this? Official authorities saying the opposite of what is true. I responded and explained why these drugs should not be used.[244]

In 2019, two European researchers finally put an end to the psychiatrists' lethal fairy tale. They re-analysed FDA trial data and included events occurring during follow-up,[245] which is the right thing to do because, in clinical practice, people also stop taking the drugs at some point. They included all ages and found double as many suicides in the active groups as in the placebo groups.

In our 2016 systematic review in the *BMJ* of the clinical study reports, we found that depression pills double suicidality in children and adolescents and increase aggression 2–3 times.[246] We had access to individual patient listings in appendices for 32 of our 70 trials and they were revealing. Considering all ages, four deaths were misreported favouring the active drug; 27 of 62 suicide attempts were coded as emotional lability or worsening depression; and the patient narratives listed homicidal threat, homicidal ideation, assault, sexual molestation, a threat to take a gun to school, damage to property, punching household items, aggressive assault, verbally abusive and aggressive threats, and belligerence.

Even though akathisia was sometimes miscoded as hyperkinesia, or not coded at all, we found it occurred twice as often on the pills than on placebo.

Our findings are important, considering the many school shootings and other mass murders where the killers were on such drugs.[247] The authorities routinely hide this in order not to raise concerns about the pills, but we know that the Germanwings pilot who took a whole plane-load of passengers with him when he committed suicide in the Alps, and that the Belgian bus driver who killed many children by driving his bus into a mountain wall, were on a depression pill.

The professional stupidity is shocking. When one of the teenage shooters in the Columbine High School massacre was found to have taken a depression pill, the American Psychiatric Association denounced the notion that there could be a causal relation and added that undiagnosed and untreated mental illness exacts a heavy toll on those who suffer from these disorders.[248] This is sickening marketing-speak copied from the industry's playbook. The other murderer had also taken depression pills.

When we published our review in the *BMJ*, adolescent psychiatrist Bernadka Dubicka accused us of harming young people because we pointed out that depression drugs increase their risk of suicide. He opined that depression in young people was undertreated; that our paper was fundamentally flawed in presentation and logic; that the results were misrepresented by the *BMJ* in its press release; and a lot else besides, which was also dangerous nonsense.[249] Marc Stone from the FDA accused us of having misrepresented an FDA study, which we hadn't, and ironically, he seriously misrepresented not only his own work but also a paper by one of his FDA colleagues.[250] We replied to these unfounded attacks.[251]

Psychiatry professor Lars Mehlum from Oslo said it was a problem that we had defined suicidality very broadly and that there wasn't a significantly increased incidence of suicide or suicide attempts.[252] He claimed it was wrong when we concluded that the drugs increase the risk of suicide in children and young people.

Other critics were equally unreasonable.[253] General practitioner Sheraz Yasin found it negligible that we had shown that antidepressants double the rate of activation or other precursor events for aggression and suicidality when given to adult human volunteers compared with placebo.[254] And many psychiatrists continued to think they could use the drugs safely in children and adolescents, e.g. Detlev Degner mentioned individualised treatments or balanced risk-benefit analysis in his second rapid response in the *BMJ*. He called it a "one-dimensional, dangerous ideology" that we suggested prohibiting the use of depression drugs in children and young people. It is not ideology but evidence-based medicine to call for a ban on using drugs that don't work and cause serious harms, including suicide. As it is impossible to predict which children will be driven to suicide because of the adverse effects of the drugs, individualised treatments cannot be practised safely, and it is dangerous to suggest this fake fix.

Psychiatrists often deny that drugs that perturb brain function can cause violence and homicide. But an analysis of 1,937 cases of violence submitted to the FDA, 387 of which were homicide, showed that violence was particularly often reported for depression pills, sedatives/hypnotics, ADHD drugs, and a smoking cessation drug that also affects brain function.[255]

In 2018, I described a tragic suicide on depression pills in a newspaper, *Jyllands-Posten*.[256] The parents of Rasmus Burchardt contacted me after their 19-year-old son had hanged himself in their bathroom 18 days after the family physician had prescribed mirtazapine for sleep problems and school fatigue. Neither they nor Rasmus had been warned that depression pills can cause suicide and they wanted me to write about it to warn others. It was

incomprehensible to them how this could have happened because Rasmus had never previously had suicidal thoughts or suffered from depression.

Rasmus' girlfriend was worried about a message he had sent the same day: "These fucking pills make the thoughts impossible to stop, and right now I want everything to stop." She went to the house with a friend and found him dead.

I explained that Rasmus' story was typical of suicides caused by depression pills. They often come without warning and the method is usually violent, e.g. hanging, shooting, or jumping in front of a train, which almost guarantees that the suicide attempt succeeds. The more common approach is to take an overdose of pills, which is often a cry for help.

My article ignited a lot of discussion. Two leading professors of psychiatry, Poul Videbech and Per Hove Thomsen, and psychiatrist Poul Erik Buchholtz, claimed that the pills *protect* against suicide.[257] Buchholtz also claimed that psychotherapy wasn't an option even though my oldest daughter Pernille and I had shown that psychotherapy for patients who have attempted suicide halves the risk of another suicide attempt.[258]

The chairman of the Danish Society for General Medicine, Anders Beich, believed that the long waiting time for psychiatrists could be disastrous, because it is dangerous to have depression, which can lead to suicide.[259] It can only be an advantage to have long waiting lists for psychiatrists who prescribe pills that double suicide rates.

In 2018–19, I informed the Boards of Health in the Nordic countries, the UK, Australia, and New Zealand that the consequence of the collective, professional denial was that children and adults continued to commit suicide because of pills they thought would prevent suicide.[260] I urged the boards to act and told them that my warnings had caused the use of depression pills in children to be almost halved in Denmark, whereas it had increased in the other Nordic countries.

I was met with indifference. I got no or late replies, meaningless replies, or outright denial of the evidence.[261] It took the Finnish Ministry of Social Affairs and Health five months to admit that "increased suicidal thoughts have been connected with SSRIs in some studies." When *all* studies are considered, it is clear that depression pills increase not only suicidal thoughts, but also suicidal behaviour, suicide attempts, and suicides, even in adults.

The Swedish Drug Agency replied after a delay of six months. It was all about processes and treatment recommendations the agency had issued in 2016, which I looked up.[262] Under side effects, suicidality wasn't mentioned at all. Further down, the document noted that the pills increase the risk of suicidality slightly, but "do not increase the risk of suicide, and there is some evidence that the risk is decreased."

This is a lie. The Swedish package insert for fluoxetine, which the agency has approved, mentions that suicide-related behaviour (suicidal thoughts and suicide attempts), hostility, and mania are common side effects in children. Some of the experts the agency had used, e.g. Håkan Jarbin, had financial ties to the manufacturers of depression pills, but none of this was declared in the drug agency's report.

In 2020, I wrote to the boards again, this time attaching my paper about their inaction.[263] The Icelandic Directorate of Health replied that they had asked the psychiatrists in charge of child and adolescent psychiatry to give their opinion nine months earlier, with a reminder, but they did not have time to respond. I replied: "They should be ashamed of themselves. Children kill themselves because of the pills and they don't have the time to bother about it. What kind of people are they? Why did they ever become psychiatrists? What a tragedy for the children they are supposed to help."

I informed Bob Whitaker about this, and he replied that the inaction by the medical profession regarding the prescribing of psychiatric drugs to children and adolescents is a form of child abuse and neglect, and institutional betrayal.

I did not get any replies from the UK or Australia. An undated letter from the Ministry of Health of New Zealand said the drug regulator had not approved the use of fluoxetine for people less than 18 years of age. However, this is no hindrance for usage, which increased by 78% for depression drugs between 2008 and 2016,[264] and a 2017 UNICEF report showed that New Zealand had the highest suicide rate in the world among teenagers.[265]

Lundbeck has been very successful in driving children to suicide. In 2023, the FDA lowered the age for which escitalopram (Lexapro) can be used, from 12 to 7 years based on a trial in generalised anxiety disorder.[266] As is usual for Lundbeck, it was marketing dressed up as science.[267] Ten of the 11 authors had a financial conflict of interest, and the manuscript was ghostwritten. The paper concluded that the drug worked and was well tolerated, both of which were wrong. Adverse events occurred in 76 of 137 children on the drug and in 51 of 136 on placebo (P = 0.004, my calculation; there were no P-values for harms in the article), and more children had suicidal ideation on escitalopram (13 versus 2, P = 0.006), "with the most common ideation in the least severe category (''wish to be dead''; 9 versus 1, P = 0.02).

Readers might wonder how, according to Lundbeck, "I wish to be dead" can be the least severe suicidal ideation category.

After the 8-week trial period, 43 children on the drug were switched to placebo cold turkey. This was unethical and violated international guidelines. It is not surprising that it caused some children to experience suicidal ideation or behaviour or that they wished to be dead (according to the supplementary material).

The effect was minor and statistically significant only for one of the three observer rating scales used. The children were not asked how they felt. They would likely have found the drug ineffective, which they did in the two fluoxetine trials in depression we reviewed.[268]

FDA's package insert for Lexapro notes that, "The safety and effectiveness of Lexapro have not been established in pediatric patients less … than 7 years of age." Sure, but it has been established for older children that Lexapro is dangerous. The package insert mentions that, for all antidepressants, for patients less than 18 years old, 14 additional patients per 1000 will experience suicidal thoughts and behaviours on drug compared to placebo. This is an unacceptable harm for drugs that don't work for children.

Under *Incidence of Adverse Reactions* are listed some minor adverse effects that are more common on Lexapro than on placebo. There are no data on the statistically significant increase in suicide risk in the trial of generalised anxiety disorder (see above), even though the package insert gives other data from this study, but only for efficacy and only for the scale where the outcome was statistically significant.

I have described the corruption at the FDA in detail in two of my books.[269] The failure in drug regulation causes some children to kill themselves, which makes the FDA complicit in this crime against humanity (see below). The only decent action is to ban the use of depression drugs in children.

Experts in suicide prevention contribute to the crime against humanity

So-called experts in suicide prevention contribute to the crime against humanity. They are biased towards drug use and cherry-pick the studies they quote even when they call their

reviews systematic.[270] Suicide prevention strategies always seem to incorporate depression pills, e.g. in a programme for US war veterans.[271]

In 2017, Norwegian researchers noted that it is a myth that mental disorders play a significant role in at least 90% of suicides.[272] In most cases, there is no pre-existing mental disorder, but a depression diagnosis is assigned retrospectively using "psychological autopsy." It is impossible to diagnose depression in a dead patient, as many of the diagnostic questions are about how the patient feels and thinks, which therefore involve speaking with the relatives who may be unwilling to disclose problems that put some of the blame on themselves.

The article by the Norwegians is convincing but was difficult to publish. They received positive peer reviews and the editor invited resubmission, but a new editor rejected the article noting that the findings "are not sufficiently incremental beyond current knowledge and are not sufficiently persuasive to back up its significant claims."

This is what philosopher Harry Franklin calls bullshit, which he considers short of lying.[273] The new editor had a conflict of interest and had stated in his own publications that mental disorders play a significant role in 95% of suicides.

The researchers went on an Odyssey with many submissions, rejections, and discussions with editors, and an interesting pattern emerged. Reviewers who concurred with their message or welcomed articles questioning established truths, provided brief reviews. Others did not debate the science but used the deplorable tactic described in *The art of always being right* by philosopher Arthur Schopenhauer, of intimidating your opponent by choosing metaphors favourable to your position.[274] The Norwegian researchers were accused of taking an extreme stance; they were unbalanced; they were not trained as psychiatrists; they were polemical; they just expressed opinions; or they were like climate change deniers.

When the article was ultimately published and the editor invited critical comments, none arrived. This is also typical. If you can't win, you had better keep quiet.

In 2017, 29 suicide prevention experts from 17 countries published a report with the authoritative title, *Evidence-based national suicide prevention taskforce in Europe: A consensus position paper,*[275] which quoted a "systematic review" conducted by 18 experts. However, the review was not systematic. It did not include the numerous studies or reviews that went against the authors' dangerous recommendation of drug therapy as suicide prevention.

It was exceedingly difficult for the Norwegian researchers to publish a criticism of the report.[276] Their paper was rejected by six journals, for political reasons.

In 2020, they published an article online with interviews of professionals about their experiences of working with the implementation of the Norwegian action plans and guidelines for suicide prevention.[277] The professionals were highly critical of the monopolisation of "the truth" within the suicide prevention community. One month after the article was published, the researchers received a letter from the editors stating that they had received a complaint about defamatory content. They wanted to republish the article but would give the researchers the opportunity to withdraw it first.

This was a trap, which I have also been exposed to. You should NEVER accept such an "offer" from an editor who will undoubtedly use the opportunity to reject your paper after additional peer review.

It was easy to guess that the complaint came from the National Centre for Suicide Research and Prevention. The authors refused to withdraw the article, which resulted in a five-month battle where they needed legal assistance from their university and from

Germany where the publisher is located. The German lawyer concluded that there was nothing defamatory in the content. In fact, the content was protected in legislation on freedom of speech.

But the theatre of the absurd continued. The editors now wanted to investigate if there was any basis in the data for what they called "strong allegations" and demanded that the interview transcripts be handed over. This would have been a serious breach of confidentiality, and the researchers refused to comply. Instead, they sent material to the editors showing that the national suicide centre had publicly confirmed their findings in several professional journals.

Then, the editors asked the university to investigate the researchers for scientific misconduct. The university gave in to this unwarranted demand and its investigation fully supported the researchers. Only then did the editors accept that the article would remain in the journal.

I corresponded with the primary author, Professor Heidi Hjelmeland, about this saga, which made me search on the Internet to find out what the "experts" opine today about using drugs for suicide prevention. A systematic review from 2021 in the psychiatrists' flagship journal, *American Journal of Psychiatry*, entitled *Improving suicide prevention through evidence-based strategies* was shocking.[278] The abstract claimed that "Meta-analyses find that antidepressants prevent suicide attempts." The psychiatrists even had the audacity to call their lethal advice "evidence-based strategies."

As already noted, in randomised trials, depression pills double not only the *risk* of suicide; they also double suicides, with no age limits.[279]

People who consider themselves suicide experts are usually just the opposite. A 2015 "state of the art review" by Bolton et al. in the *BMJ*[280] about suicide risk assessment and intervention is a narrative review with a curious mix of randomised trials, observational studies, cross-sectional studies, retrospective analyses, and conclusions based on flawed data.[281] They say that some drugs can decrease the risk of suicide, but their references do not support this.

Their first reference is a narrative, unsystematic review by Griffiths et al. where, for antidepressants, one trial said this and another trial said that, and there was a *post hoc* analysis and empty jargon like "there is some evidence." Griffiths et al. say that clozapine is the only drug approved by the FDA for reducing the risk of suicidal behaviour.

But the FDA fooled us yet again. There are no placebo-controlled trials documenting that clozapine reduces the suicide risk. Oddly, this claim comes from a huge trial with olanzapine - another neuroleptic - as comparator.[282] It randomised 980 patients with schizophrenia or schizoaffective disorder at high risk of suicide. The differences were barely statistically significant, P = 0.03, both for suicidal behaviour and attempted suicide. Obviously, we cannot exclude the possibility that both drugs might increase suicides, but that clozapine does this to a slightly lesser degree than olanzapine, but the FDA didn't care. Furthermore, P = 0.03 could be a chance finding or a result of torturing your data till they confess.[283] Actually, the trial found that there were *more* suicides on clozapine than on olanzapine (five versus three). Novartis, the manufacturer of clozapine, was behind the trial, and 6 of the 13 authors were conflicted.

Bolton et al. claim that lithium reduces suicides, referring to a narrative review that in its abstract speaks about "large-scale, retrospective and prospective naturalistic long-term clinical studies." A systematic review in *BMJ* of randomised trials of lithium is far more

cautious,[284] and the placebo group could have an artificially increased risk of suicide because of withdrawal symptoms, as the patients were already on lithium before being randomised.

In 2017, suicide experts wrote in the *Swedish Medical Journal* that antidepressants, lithium, and clozapine prevent suicides, but several of their references were seriously misleading, and I noted that there is no reliable evidence that any drug can prevent suicide.[285]

In my book about organised crime in the drug industry, one of the chapters is, *Pushing children into suicide with happy pills*.[286] Can anything be worse than this in healthcare? Telling children and their parents that the pills are helpful when they don't work and drive some children to suicide? Isn't this a crime against humanity?

The NIMH has a webpage about suicide prevention which mentions nine risk factors.[287] Depression pills are not among them, and the information is seriously misleading in other ways. It says that, "Some individuals at risk for suicide might benefit from medication" and that clozapine - a particularly dangerous neuroleptic - is approved by the FDA "for reducing the risk of recurrent suicidal behavior in patients with schizophrenia or schizoaffective disorder."

A 2022 *Lancet* seminar was yet another proof that psychiatry has degenerated to a point of no return. The seminar, *Suicide and self-harm*,[288] was 14 pages long. *Lancet* is considered a prestigious journal, which it isn't. A journal that does not accept letters for publication if they are longer than 250 words and if they don't arrive within two weeks after the original article, does not invite criticism and scientific debate. Many people will not know an article has been published before it is too late to criticise it.

The seminar is one of the worst articles about suicide I have seen, which I explained on the Mad in America website.[289] The authors wrote that there are "associations between suicidal behaviour and dysregulation of the hypothalamic-pituitary-adrenal axis and serotonergic neural transmission." They tried to resurrect the myth about a chemical imbalance in the brain being the cause of psychiatric disorders,[290] but the two references they cited were gobbledygook, alluding to epigenetic modification of genes, alterations in key neurotransmitter systems, inflammatory changes, glial dysfunction, hypo-thalamic-pituitary-adrenal axis dysfunction, and genetic predisposition.

Among risk factors for suicide, they mentioned substance use but not depression pills, antiepileptics (which double the risk of suicide[291]), or the psychiatric profession itself.[292] These are taboos for suicide researchers. It was also dishonest to say that "The use of medication to prevent suicide is controversial" and that there is a "possibility of exacerbating suicidal thoughts, particularly in young people." We *know* that depression pills double suicide rates.

There were 142 references but not a single one to any of the many meta-analyses of placebo-controlled trials showing that depression pills increase the suicide risk. Instead, they quoted a book written by the last author of the seminar and by Robert D Goldney who has published a review that is a classic example of how one should not do a review.[293] He cherry-picked observational studies that supported his idea that depression pills protect against suicide, e.g. studies conducted in the Nordic countries that are scientifically dishonest.[294] Other Nordic researchers have shown that there is no association between increased sales of SSRIs and the decline in suicide rates, which in Denmark and Sweden predated the introduction of SSRIs by ten years or more.[295] Goldney had "received honoraria and research grants from a number of pharmaceutical companies." No surprise there.

The seminar authors claimed, with no references, that drug treatment can reduce the suicide risk. What are the miraculous drugs that can do this? It seems they only exist in the delusional world of the psychiatrists.

A little later, the authors spoke about observational studies suggesting that antidepressants might reduce the risk of suicide. This is the UFO trick: If you use a fuzzy photo to "prove" you have seen a UFO when a photo taken with a strong lens has clearly shown that the object is an airplane, you are a cheat. They claimed that randomised trials were underpowered, which is not true if we combine them in meta-analyses.

They wrote that *some* research has found an *association* with increased risk of suicide-related outcomes in young people. This is also dishonest. When the FDA looked at *all* the randomised trials, they found a causal relation and not just an "association."

They claimed that the evidence base is incomplete, since many trials excluded people at high risk of suicide. This is nonsense. We have all the data we need to conclude that depression pills double suicide rates.

About the latest fad in psychiatry, hallucinogenic drugs, they wrote that "Ketamine has shown promise." It hasn't (see page 23).

The Lancet is the extended marketing arm of the pharmaceutical industry,[296] just like the *New England Journal of Medicine*, which has also published articles denying that depression pills cause suicide.[297]

In 2023, the "experts" failed us badly again. In a long article (6,425 words) in *BMJ*, *Suicide in young people: screening, risk assessment, and intervention*, Hughes et al. mention some risk factors, e.g. living in a home with firearms.[298] They do not mention treatment with depression drugs. Later, they say the drugs might increase suicidal thinking and behaviour but nonetheless recommend them for young people, with "increased monitoring by the prescribing physician." We know this is a fake fix, as people can kill themselves suddenly and unexpected, just like it doesn't work to warn against the firearms in people's homes.[299]

Hughes et al. believe a risk difference of 0.7% for suicidal ideation or suicide attempt between drug and placebo is small, and they immediately dismiss it by saying that "Data from more recent pediatric antidepressant trials have not shown differences between drug and placebo." The review they quote cannot be used to such effect. And when studying rare events, it is unacceptable to lose statistical power by including only "recent" trials. Moreover, the review only included published trial reports, which have omitted many suicide attempts and suicides.

It is irresponsible of the *BMJ* to publish such dangerous nonsense.

In September 2023, I looked into the suicide issue again.[300] I did a Google search in Danish on "suicide and antidepressants," which confirmed that the public is being massively and systematically misinformed. Here are the top 10 posts:

The first was a report from the Danish Centre for Suicide Research showing that antidepressants increase the risk of repeated suicide attempts by 50%.[301] However, after the researchers had adjusted their analyses for many factors including psychiatric contact and use of various psychiatric drugs, they concluded that the pills do not increase the risk of another suicide attempt. The research was supported by Lundbeck. No surprises there.

As already noted, it is wrong to adjust for something that is part of the causal chain, which can remove any true relationship. Serious mental illness can lead to psychiatric contact, the use of psychiatric drugs, and a suicide attempt.

Number two was a message addressed to Danish citizens from Psychiatry in the Capital Region: *Risk of suicide and violence is not affected by antidepressant therapy*.[302] They referred to a Danish registry study, but such studies are biased in numerous ways and cannot invalidate the results obtained in placebo-controlled trials.

Number three was from the same institution: *Antidepressants do not increase the risk of suicide. Fluoxetine and venlafaxine do not increase the risk of suicide among young people. Among adults and the elderly, the drugs protect against suicide*.[303] They referred to a meta-analysis by Gibbons from 2012. Gibbons uses statistical modelling, and his studies are so dishonest that it is not a question of errors, but of deliberate cheating.[304]

Number four was an article[305] from an industry-funded magazine about our study that found that, in adult healthy volunteers, depression drugs double the risk of suicide and violence compared with placebo.[306] This was stated in the article as a risk of 15.2% versus 10.3% (a risk ratio of only 1.5). These numbers do not appear in our article and cannot be derived from it.

Number five was an agreed wording from the Danish Drug Agency for the text in the package inserts for antidepressants:[307] "Since an improvement in the depression may not be seen until after several weeks of treatment, the patient should be followed closely until an improvement is seen. General clinical experience shows that the risk of suicide may increase in the early stages of recovery."

It is deeply irresponsible to give people the impression that antidepressants reduce the risk of suicide. Furthermore, "general clinical experience" is unreliable. The agency should have said that the placebo-controlled trials show that the risk of suicide is increased, not just at the start of treatment, but at any time, and especially after dose changes.

Number six was an article in the *Journal of the Danish Medical Association* by psychiatrist Marianne Breds Geoffroy:[308] *Youth suicide and antidepressants: Peter Gøtzsche claims that antidepressants have driven young people to suicide. But how can he know that?* Well, that's easy. When a drug increases the risk of suicide, some will succeed.

Geoffroy begins her article this way: "Peter Gøtzsche writes that it is antidepressants that have 'driven young people to suicide.' If that is correct, then why are not all children and young people who have depression and are given antidepressants driven to suicide?" Well, some people die in traffic accidents, but we don't all die. Geoffroy had received fees from Lundbeck, Eli Lilly and Novartis.

When my first psychiatry book came out, Geoffroy wrote in an industry supported magazine that I used public funds (which wasn't true) to publish private, non-scientific books, which she compared to Scientology books.[309] She addressed the Minister of Health and asked in the headline: *Which office stops professors gone astray?* claiming that I scared patients away from getting relevant treatment. She obviously attempted to get me fired.[310] I complained about her libellous misinformation. A tribunal concluded she had violated the ethical guidelines and the collegiate guidelines from the Danish Medical Association and had used language that was totally beyond the borders of a decent debate about healthcare issues.[311]

A month later, in the article, *No one above Gøtzsche*, she once again called my governmental funding into question.[312] She called it bizarre to do as I did, "to extrapolate from the few unfortunate cases to the many … That's how bad things can go when a statistician leaves the desk and strays into real life." What is bizarre is that most patients are unhappy with the "help" they get from psychiatry, but she claims it is very few. She also called my book about organised crime in the drug industry, "The first dark book."

A year later, Geoffroy was on the warpath again.[313] She claimed it was an ideology and a conflict of interest that we had suggested we should demedicalise the population because psychiatric drugs are the third leading cause of death.[314] I thought that all doctors were interested in helping their patients to survive and I wrote that, since there was no substance in her criticism, she apparently looked for something else to criticise me for. She complained about me to my management, my boss at the university, the Board of Health, the Minister, and the committee at the university that handles alleged cases of scientific misconduct. I noted that anyone can report his neighbour to the police, but sometimes it is the complainant who is the problem, and not the one complained about.

Number seven was a mention in the *Journal of the Danish Medical Association* of psychiatrist Lars Søndergård's PhD thesis.[315] It was based on Danish registries and found "a reduced risk of suicide associated with continued treatment for all groups of antidepressants," the opposite of what the randomised trials have shown.

Number eight was a comment I made in 2015 on the Board of Health's website.[316] Poul Videbech had claimed in the Board's journal, *Rational Pharmacotherapy*, that undertreatment with antidepressants is dangerous because of the suicide risk. I noted that this cannot be correct because antidepressants increase the risk of suicide, and I pointed out other errors in Videbech's article.

Number nine was a mention on a science site[317] of my research group's meta-analysis, which demonstrated that duloxetine increases the risk of suicide and violence 4–5 times in middle-aged women with urinary incontinence, as judged by FDA defined precursor events.[318] Furthermore, twice as many women experienced a core or potential psychotic event. Psychiatrists have criticised our use of precursor events for suicide and violence, but this is similar to using prognostic factors for heart disease. As smoking and inactivity increase the risk of heart attacks, we recommend people to stop smoking and start exercising.

Number ten was my article about Rasmus Burchardt's suicide I described above.[319]

Google searches are influenced by the searcher's previous searches, but it is clear that many leading psychiatrists have failed in their responsibility to the public by claiming that depression pills protect against suicide. I don't know of any other medical specialty whose practitioners systematically lie to the public in matters of life and death. Several psychiatrists have told me that their leaders suffer from cognitive dissonance, as what they see and hear doesn't influence them.

In April 2024, Katinka Blackford Newman launched a petition, "Get suicide prevention services to ask callers if they are taking meds that cause suicide," to the *Samaritans*, which is a suicide prevention service.[320] It got over 25,000 signatures in just two months.[321] She did this because experts she had talked to had suggested that medical professionals and helpline staff should ask people with suicidal thoughts: "Have you become suicidal since going on, changing dose, or coming off a drug that lists suicidal thoughts as a potential side-effect?"[322]

When she contacted the *Samaritans*, a spokesperson said: "Our listening volunteers are not medically trained clinicians and do not offer advice on prescription medication. Discussions about treatment options, including any possible side-effects, must be had with a GP or other qualified healthcare professional."

In Professor David Healy's view, while suicide prevention services cannot be expected to offer medical advice, "they could raise the possibility with callers that their problems may be caused by medication and that if there's a risk, they should go back to their doctor or seek medical advice."

They surely could, and they must do this and abandon the taboo that suicide can be caused by drugs. This taboo kills people.

The psychiatric leaders have given up rational thinking for the benefits they acquire from supporting a sick system. An example of this was when Bob Whitaker's widely acclaimed book, *Anatomy of an epidemic* came out in Danish.[323] It won the Investigative Reporters and Editors book award for best investigative journalism in 2010, but Poul Videbech wrote about the book that the thesis Bob wants to prove is that psychiatric treatments make people sick, which he does in such a way that all studies that speak in favour are referenced and all that speak against are systematically ignored: "The author, who is a journalist, cannot of course familiarise himself more closely with the original scientific literature."[324] Videbech's arrogance was even apparent in the title: *The boy has no clothes*, paraphrasing *The emperor's new clothes*.

Bob's approach was systematic. He set out to investigate what psychiatric drugs do to people, not to prove a preconceived thesis, and he has a superb capability to analyse research and to understand if it is reliable or not, in stark contrast to Videbech. Moreover, Bob has searched meticulously for any study that showed that psychiatric drugs improve long-term outcomes. There is none. All the long-term studies that exist tell a story of serious drug harms (see pages 149–154).

Under the heading, *It is the emperor who is naked*, general practitioner Herluf Dalhof delivered a crushing criticism of Videbech's disparaging review of Bob's book, which he called ground-breaking.[325] Videbech downplays the explosive development in the number of psychiatric patients who have been disabled by their medical treatment by using old data from 1955–87. He claims that "there are not many references to scientific studies," but there are 320 references to articles in scientific journals as well as numerous references to reviews from the NIMH and other official institutions. Videbech also claims that "the notes are from the 1960s–80s with a few newer ones, which is also untruthful as Bob kept the material up to date till shortly before the book's publication.

Dalhof noted that it is a thorn in Videbech's flesh, that it is a science journalist who has documented the scandal that psychiatrists have – in a brain-dead fashion - continued to treat the mentally ill with toxic chemicals, even though the evidence that these chemicals in the long term make patients sicker has existed for over 30 years.

He was surprised that Videbech cannot see the writing on the wall: That the treatment of our mentally ill has gone so far off track that even a journalist can see it. He ends by saying that Bob's book should give rise to serious self-examination among psychiatrists regarding their so-called treatment of our mentally ill.

Fraud in the two pivotal trials of fluoxetine in children with depression

As fluoxetine (Prozac) from Eli Lilly was the first SSRI approved for depression in children and adolescents, I decided to scrutinise the two placebo-controlled trials that led to its approval. I involved psychiatrist David Healy in this work who adjudicated the adverse events.

Fluoxetine was approved even though FDA's statistical reviewer noted that there wasn't a statistically significant benefit for the drug on the primary outcome in either trial.[326]

I examined the 3,557 pages of clinical study reports Eli Lilly had submitted to the drug regulators and we concluded that fluoxetine is both unsafe and ineffective. Essential information was missing; there were unexplained numerical inconsistencies; new outcomes

appeared that were not prespecified in the trial protocol (the Texas sharpshooter fraud); rating scales and analyses were changed; and the trial protocols were violated in other ways.

The efficacy outcomes were biased by differential dropouts and missing data, but even so, the effect was only 4% of the baseline score, which is not clinically relevant, and patient ratings did not find fluoxetine effective at all.

Suicidal events were missing in the internal study reports and two suicide attempts were omitted from the publication of one of the two trial reports. Precursors to suicidality or violence occurred more often on fluoxetine than on placebo, and for the biggest trial, the number needed to harm was only 6 for nervous system events (a category used by Eli Lilly) and 10 for severe harm. Even though the trials only ran for some weeks, fluoxetine reduced height and weight by 1.0 cm and 1.1 kg, respectively, and it prolonged the QT interval on the ECG (which increases the risk of sudden death). Many children developed symptoms compatible with akathisia.

Strangely, a subsequent publication by Lilly staff had other numbers of suicidal events than those in Lilly's study reports,[327] and a 2007 Lilly meta-analysis of violent events in its trials reported that *fewer* children and adolescents displayed aggression or hostility-related events on fluoxetine (2.1%) than on placebo (3.1%),[328] the opposite of what is correct.

Lilly's rosy results were contradicted by our findings and FDA's assessment of Lilly's application. The FDA included a trial of obsessive-compulsive disorder and found 14 vs 3 discontinuations (P = 0.02, my calculation) for reasons related to suicide and violence, and 6 versus zero children developed mania or hypomania (P = 0.03).[329] A systematic review of all drugs showed that 8% of children treated with pills developed mania or hypomania versus only 0.2% on placebo.[330] A systematic review including all ages also found an 8% rate.[331]

Fluoxetine is a horrible drug that should never have been approved. But Lilly was in financial trouble and turned their drug, which they had wanted to shelve, into a blockbuster. Lilly's frauds are second to none, but other drug companies also indulged in fraud and organised crime and the drug regulators were complicit in this.[332]

David Healy had expected a firestorm when we published our review but there was total silence. The only person that has cited it in a medical journal is me.[333] No one took any interest in our shocking revelations, which shows how corrupt psychiatry is.

The two prestigious journals that published the two fluoxetine trials are also corrupt. In August 2023, I wrote to the editors and called for retraction of three fraudulent reports of placebo-controlled trials of depression drugs in children and adolescents, including a study of paroxetine (known as GSK study 329).[334] Ten people who lost a child or spouse to suicide as a consequence of being prescribed a depression drug for a non-psychiatric condition - issues that all of us can experience - were co-signatories.

All three trial reports seriously underreported the suicide risk and provided false claims that the drugs are effective.

We told the editors of *Journal of the American Academy of Child & Adolescent Psychiatry* and *JAMA Psychiatry* (previously *Archives of General Psychiatry*) that, "By retracting the fraudulent trial reports and explaining why in accompanying editorials, you will provide a much-needed service to the scientific community and the world's citizens, which will reduce the risk of additional meaningless suicides in children and young people. If you don't act, you will not only sully the reputation of your journals. You will also be seen as being complicit in future suicides caused by antidepressants as a direct harm of these drugs."

Anette Flanagin, Executive Managing Editor, Vice President, Editorial Operations, *JAMA* and *JAMA Network*, replied that she had shared our letter with the author and that "he does

not identify any new concerns. Similarly, we do not find new evidence in support of your request to retract this article."[335]

So, *JAMA* and Graham Emslie, who omitted to mention two suicide attempts on fluoxetine in his trial report and who made numerous other errors, think this is nothing to bother about. Flanagin asked the person responsible for the fraud about his views and accepted them. I wonder if she would recommend this method for the police when they investigate a murder. Just ask the suspect if he did it, believe what he says, and ignore all evidence to the contrary.

We asked Flanagin, in the public interest, to reconsider her decision, and, if she still didn't want to retract the paper, to publish an erratum. We also asked her to send Emslie's reply to us and give us the opportunity to publish an account of the many errors in his article, asking him to respond in the same issue.

Flanagin did not respond. And when I contacted Elsevier, the journal's owner, they did nothing but directed me back to the journal.

Douglas K. Novins, Editor-in-Chief, *Journal of the American Academy of Child & Adolescent Psychiatry*, replied: "Following guidelines developed by the Committee on Publication Ethics (COPE), independent groups comprised of members of the *JAACAP* senior editorial team have now thoroughly reviewed your critique, as well as the responses provided by the papers' authors. We are satisfied that the critiques of the papers as outlined do not merit retraction."

I sent a similar message to Novins as my appeal to Flanagin, but he did not reply. It is hard to believe that he followed the COPE guidelines, as the two trial reports, by Emslie and Martin Keller, are clearly fraudulent.

There has been one independent randomised trial of fluoxetine in adolescents, the US National Institutes of Health's Treatment of Adolescent Depression Study (TADS), published in 2004.[336] This trial was very large and influential.

The TADS authors claimed efficacy and safety for fluoxetine, the standard mantra for drug industry trials, but both claims are wrong. The effect was not clinically relevant, and there were twice as many suicidal events on fluoxetine than on placebo.[337]

Despite over 30 publications, the harms remain misreported. Two researchers got access to summary data via the NIH, which showed 12 versus 2 suicide attempts.[338] When they tried to get access to the case record forms and narratives for serious adverse events, Duke University, where the trial data were lodged, refused to deliver the data even though they had signed an agreement about this.

The researchers also tried to get the missing data from Lilly, which provided fluoxetine for the trial and had received all the serious adverse events reports from the investigators, but Lilly refused to release the data or to have any of the correspondence published.

When the researchers tried to get the data from the FDA, they were told it would take at least two years before they came up in the queue.

A psychiatric textbook mentioned a meta-analysis and claimed that fluoxetine is the only drug with a significant effect in children and adolescents and also the best tolerated.[339] Such claims belong to the realm of science fiction. It is impossible – and I have never seen an example of this – that a drug can be more effective and better tolerated than other drugs in the same class. There was no reference, but the source can only be the unreliable 2016 network meta-analysis by Andrea Cipriani and colleagues (see page 24).

Another textbook acknowledged that fluoxetine increases the risk of suicide in children but recommended an increase in dose in suicidal children! This is like saying that if driving

100 km per hour increases your risk of dying, it will be safer to drive 200 km per hour. It is not surprising that critical psychiatrists have a hard time in this insane system.

More fraud and misinformation driving children to suicide

A court case revealed that, after licensing fluoxetine for children, the FDA issued an approval letter in 2002 for paroxetine from GlaxoSmithKline:[340] "We agree [with GSK] that … the results from Studies 329, 377, and 701 failed to demonstrate the efficacy of Paxil in pediatric patients … Given the fact that negative trials are frequently seen, even for antidepressant drugs that we know are effective, we agree that it would not be useful to describe these negative trials in labeling."

This is one of the most horrible statements I have ever seen a drug regulator make. The drug didn't work, but we know it works, so we will approve it. This is how practitioners of homoeopathy or Chinese medicine and other quacksters argue.

In the publication of study 329, GSK claimed paroxetine was safe and effective.[341] But they knew both claims were wrong. The study was negative for all eight protocol-specified outcomes and positive for harm, but GSK tortured the data till they confessed,[342] and the paper didn't leave any trace of the torture. It falsely stated that the new outcomes were declared *a priori* - the Texas sharpshooter fraud (see page 27).

New York State's Attorney General lodged a fraud action against GSK in 2004, which made it possible to access the real data. Seven children on paroxetine versus one on placebo demonstrated suicidal or self-injurious behaviour.[343] But in the published paper, five cases of suicidality were called "emotional lability," and three other cases were "hospitalisations."[344] When the FDA demanded the company to review the data again, there were four additional cases of intentional self-injury, suicidal ideation, or suicide attempts, all on paroxetine.

The first author on the fraud, Martin Keller, double-billed his travel expenses; was offered $25,000 for each vulnerable teenager; received hundreds of thousands of dollars to fund research that wasn't being conducted and similar amounts from drug companies every year, which he didn't disclose; lectured for patients and their relatives on drug company money, which he didn't reveal; and his honoraria were whitewashed.

Keller's many misdeeds didn't harm his career, likely because his department had received $50 million in research funding. A spokesperson from Brown University School of Medicine said that "Dr Keller's research regarding Paxil complied with Brown's research standards."

The *Journal of the American Academy of Child and Adolescent Psychiatry* that published Keller's paper was complicit in the fraud. The journal's editors were shown evidence that the article misrepresented the science, but they refused to convey this information to the medical community or retract the article.[345] An explanation for this editorial misconduct can likely be found by following the money that goes to the journal's owner.

As we found for fluoxetine, paroxetine seemed to stunt growth, and the FDA requested GSK to do animal studies to evaluate this, which GSK ignored, and FDA didn't insist on it.

In 2004, the FDA issued a Black Box Warning on depression pills because they double the suicide risk in young people. However, when the FDA published this in a medical journal, they called it a "modestly increased risk."[346] One in 50 children becoming suicidal on the pills is not a modestly increased risk. It is a catastrophe.

In 2009, two of my colleagues, Leemon McHenry and Jon Jureidini, wrote to the then editor of *JAACAP*, Dr. Andrés Martin, and asked him to retract study 329, as it violated the journal's own rules about scientific misconduct on multiple counts, which included fabrication and falsification of data.

In 2011, Leemon and Jon informed all the study's 22 authors of the fraud and asked them to write to *JAACAP* to have their paper, or at least their own names, withdrawn. With many co-signatories, they also wrote to President Ruth J. Simmons of Brown University where Keller worked, alerting her to the serious breach of the university's own rules, and asking her to write to *JAACAP* in support of their request for retraction.

Three years later, in 2012, Andrés Martin, wrote to Jon that the journal's editorial team had undertaken a thorough evaluation of the article because GSK had pleaded guilty to crimes that involved paroxetine.[347] The editors had reviewed the legal settlement and related materials and had asked the authors of the article to respond to the questions and concerns raised by the settlement. They found no basis for retraction or other editorial action, and they refused to publish a letter Leemon and Jon had submitted to the journal.

In 2013, The Executive Committee of the Northern California Regional Organization of Child and Adolescent Psychiatry wrote a letter to the Ethics Committee at the American Academy of Child and Adolescent Psychiatry, the owner of *JAACAP*. They noted that the FDA's Clinical Review of study 329 considered it a failed trial, in that neither active treatment group showed superiority over placebo. But publicly, study 329 was called "cutting edge research." GSK lied to its sales force, telling them that it showed "REMARKABLE Efficacy and Safety,"[348] while the company admitted in internal documents that the study didn't show the drug was effective.

The Committee noted it was troubling that the journal had not retracted the "fraudulent article" and that three of the members were told that the Ethics Committee was instructed not to investigate the paper. They asked the Committee to conduct a full investigation, in line with the Mission of the Academy: "To promote the healthy development of children, adolescents, and families through research, training, advocacy, prevention, comprehensive diagnosis, and treatment."

Nothing came out of their initiative. They were fobbed off with an excuse about editorial independence and a patronising dismissal: The Editor assured them there was no cause for concern.

In 2004, Karen Wagner et al. published a fraudulent trial report in *American Journal of Psychiatry* claiming that citalopram significantly improved depressive symptoms compared with placebo in children and adolescents. But the drug was not better than placebo. The data manipulations were revealed in a class action lawsuit and published by Jay Amsterdam, Jon, and Leemon in 2016.[349]

The fraud was major and internal documents showed that company staff were aware of the problems. Contrary to the study protocol, children who should have been excluded were included in the analyses to produce statistical significance; an implausibly large effect size was claimed, which was subsequently proven wrong; positive *post hoc* outcomes were introduced while negative primary and secondary outcomes were not reported; and substantial agitation in the citalopram group - which could be akathisia - was hidden.

Lundbeck's partner, Forest, intentionally misled the FDA about study protocol violations that invalidated the claim that the study was positive.

In 2016, Amsterdam, Jon, and Leemon asked Wagner to write to the editor and request him to retract the paper, or at least to withdraw her own name from the article. She didn't reply.

They also asked the current editor, Robert Freedman, to retract the article. When he refused, they asked the editor who accepted the paper, Nancy Andreasen, to support retraction of the article, but she also didn't reply.

They informed Maria A. Oquendo, President of the American Psychiatric Association, about the scientific misconduct in their membership journal and asked her to take action. She didn't reply and nothing was done. None of the many authors of the fraudulent trial reports asked to have their name removed.

It is sad that prestigious psychiatric journals, leading psychiatrists, universities, professional organisations, and the FDA are reckless. They apparently don't care that their activities make them complicit in suicides among children and in harming them in numerous other ways. Psychiatric journals constitute what three US child and adolescent psychiatrists who were appalled by the ubiquitous corruption in an internal email called "Liars' club."

We know with certainty that depression pills do not work for depression in young people. A 2022 meta-analysis found an effect size of 0.12 using the Children's Depression Rating Scale-Revised (CDRS-R),[350] which is so tiny that it has no clinical relevance. And if you ask the children what they think, there is no effect at all.[351]

It is threatening to the psychiatric guild that depression pills, the most used drugs in psychiatry, increase suicides and violence, and the textbooks were untrustworthy.[352]

Two books that referred to the suicide risk in young people failed to warn that any dose change increases the suicide risk. One book noted that akathisia can *possibly* cause suicidal thoughts or actions (this is a fact, not a possibility), and one book noted that the pills *tend* to increase the suicide risk in youngsters, in connection with the start of treatment (it is a fact that they do this, and it is not only at the start of treatment).

Two books stated that psychomotor inhibition often subsides before the mood rises, which may give the necessary energy to commit suicide. It has never been documented that the pills increase the suicide risk because they remove inhibitions. This psychiatric folklore is a smart way of turning a drug harm into something positive: It's a sign that the drug works, they say.

Another book mentioned that untreated depression can be harmful and cause suicidality, and it recommended SSRIs. In a 20-page chapter about preventing suicides, the authors claimed that SSRIs seem to reduce the extent of suicidal thoughts. They did not provide any references to this blatantly false statement. In this textbook, the "suicide experts" claimed that an effect has not been demonstrated of depression pills or mood stabilising drugs on suicidal behaviour or suicide. An effect has surely been demonstrated, albeit a harmful one, as both depression pills and antiepileptics[353] double the risk of suicide.

Two books claimed that increased use of depression pills had *decreased* suicides. There is a wealth of such misleading studies. They are all unreliable and of poor quality and some are fraudulent, as I have demonstrated.[354]

Websites are also misleading. We showed that 25 of the 39 most popular websites from 10 countries stated that depression pills may cause suicidal ideation, but 23 of them contained incorrect and sometimes dangerous information.[355] Only two websites noted that the pills increase the suicide risk in people of all ages.

More lies and medical malpractice

The UK drug regulator described withdrawal reactions as generally being rare and mild but had classified them as moderate in 60% of the cases and as severe in 20%.[356]

In 2003, GlaxoSmithKline (GSK) quietly and in small print revised its previous estimate of the risk of withdrawal reactions for paroxetine (Seroxat or Paxil) in the prescribing instructions from 0.2% to 25%,[357] an increase of 100 times.

From 2002 onwards, the *BBC* presented four excellent documentaries made by Shelley Joffre about SSRIs in its Panorama series, the first one called *Secrets of Seroxat*. The GSK spokesperson, Alastair Benbow, lied. He denied that paroxetine could cause suicidality or self-harm, while he sent data to the drug regulator one month later that showed exactly this, which led to a ban on using the drug in children. The UK drug regulator claimed that this information was completely new to GSK, but the company had known about it for ten years. The head of GSK also lied, saying it was the disease, not the drug, that caused the suicidal events.

Depression pills can cause homicide, and the main triggers are akathisia, emotional blunting and psychosis. Many people who have committed homicide while taking depression pills were normal before starting them, developed akathisia when taking them and returned to their normal personality when they came off the offending drug.[358]

In many cases, the psychiatrists were guilty of medical malpractice and therefore contributed to the homicide.

When I was an expert witness in a double homicide case in Holland in 2016,[359] I emphasised that serious professional malpractice played a crucial role. Aurélie Versluis had killed her two children while having indisputable symptoms of akathisia on paroxetine but her pleas for help were ignored. When she became suicidal, instead of withdrawing the drug, her psychiatrist advised continued use.

Versluis told two people about nightmares where she slit her children's throats (which she ultimately did, and also tried to commit suicide). Two days prior to the homicides, she told her supervisor and several other people that she was ill and was not feeling well. She visited her family doctor (who had prescribed paroxetine) and her company doctor with her complaints, both dismissed her, and she contacted her psychologist who did not have time for her.

It is a gruesome story. She was not herself, which a forensic psychiatrist confirmed three days after the homicides, but her doctors continued to harm her. They stopped paroxetine cold turkey when she was in the psychiatric penitentiary, causing serious harm that persisted for five months. She got a long jail sentence, but questions were raised in parliament if the judicial system was too harsh. Indeed. She should have been released because of drug-induced insanity.

The expert for the prosecution, Anton Loonen, did not have any arguments against my testimony, which included a criticism of his own report to the court. In the middle of the proceedings, he suddenly handed over a document to the court he had written in Dutch. He suspected I suffered from a mental disorder that made me seriously disinhibited and advised that I should be examined by a doctor to protect myself from myself. This was the third time I had been "diagnosed" by someone with a psychiatric background who did not know me and had not examined me but held some grudge against me.

Later, I complained over Loonen's unethical conduct to the institutions where he worked and to the Dutch Medical Association, which turned me down with the excuse that I was not a Dutch doctor. In every instance, I was told it was none of their affair, or that I should complain elsewhere. The University of Groningen ignored me for two years. It took six emails before they reacted. I was informed that, during a meeting the Dean had arranged, Loonen was told that his conduct was inappropriate and that he must prevent the university from suffering possible damage because of his behaviour.

The prosecutor asked for a 14-year jail sentence for Versluis and a hospital order for compulsory treatment. I replied to Versluis's lawyer that nothing would work for her other than keeping her away from psychiatric drugs.

Loonen realised he was in trouble and sent me a curious letter a month after the proceedings. He wrote that Versluis had been sentenced to 9 years in prison followed by preventive custody. He mentioned misunderstandings in court and claimed that his defamatory note about me - which he had openly distributed in court - was confidential. He disagreed about akathisia and considered himself an expert on this. He ended his letter by saying he was anxious to learn why I called psychiatry a pseudoscience and that he would like to invite me to dinner to discuss the background of my "ideas and feelings." The letter opened with "Dear Peter" and ended with "warmest regards." The atmosphere between us was not warm; it was ice cold. He had provided unjustifiable support for the prosecution, which I think is unforgivable.

Four months after the proceedings, I went to Holland to lecture about psychiatry at an international meeting in Leiden.[360] Loonen tried to prevent me from speaking. He wrote to the organiser referring to the court proceedings and claimed that I, for personal reasons, had violated the requirement of confidentiality as an expert witness by making public his reports to the court. This was not true. I had shown his defamatory note to a journalist, which I was entitled to do as there was nothing confidential about it, and I needed someone to translate it for me during a break in the proceedings. Interestingly for me, another speaker, Allen Frances - once regarded as the most powerful psychiatrist in the United States - said during his talk in Leiden that I had provided a tremendous service to psychiatry.

The case was appealed to the Dutch Supreme Court. Versluis's lawyer wanted me to participate but this was rejected by the court, arguing that I could not provide unbiased research into the case because I had already presented my views. Where is the logic in this? Even if you do your best to be unbiased, the mere act of participating disqualifies you!

Versluis' case constitutes a serious miscarriage of justice. I succeeded in making contact with her in 2024. She is out of prison, has a job and a boyfriend, and is well-functioning. She must be a very strong person.

Another horrible case of medical malpractice involved award-winning British documentary filmmaker Katinka Blackford Newman. While going through a divorce in 2012, she was prescribed escitalopram (Cipralex or Lexapro, from Lundbeck) even though she was not depressed, only distressed.

Katinka invited me to the launch of her book, *The pill that steals lives*,[361] in 2016. She told the audience that she was very lucky to be alive, and not serving a life sentence if she had killed her two children after the pills made her psychotic.[362] She has made a very moving 8-minute film[363] about her story and has a homepage,[364] with links to documentaries and with stories about people who killed themselves or others or were seriously harmed in other ways.

Katinka ended up in the private Florence Nightingale psychiatric hospital in central London. The psychiatrists didn't realise it was the pill that had made her ill. They diagnosed psychotic depression and forced her to stay and take a dangerous cocktail of drugs. But her 11-year-old son Oscar knew it was the pills. What saved her was that her private insurance ran out.

As an introduction to her book, I wrote: "This book describes in vivid detail how ordinary people can become murderers if they take antidepressant drugs and how psychiatry can destroy people. It is a catching personal testimony about what is wrong with psychiatry, its love affair with unscientific diagnoses and harmful drugs, and its blindness towards the fact that what look like psychiatric diseases are often side effects of psychiatric drugs."

A third example of medical malpractice is a 26-year-old woman who tried to kill her two children on two occasions.[365] She was prescribed paroxetine for stress but experienced an episode of rage, attempted suicide, and stopped taking the drug. Despite this, she was prescribed paroxetine again two years later and was reassured about its safety. This time, she developed akathisia. She overdosed and was admitted to hospital where the paroxetine dose was increased! When she tried to kill herself again, she was diagnosed with "adjustment disorder." She was switched to venlafaxine, developed akathisia again, and tried to kill her children and herself again!

In 2001, a jury found a drug firm liable for deaths caused by a depression pill.[366] Donald Schell, aged 60, had taken paroxetine for just two days when he shot and killed his wife, daughter, granddaughter, and himself. Confidential company documents showed that volunteers had experienced anxiety, nightmares, hallucinations, and other harms within two days of taking the drug, and there were two attempted suicides. However, GSK, which took over SmithKline Beecham, lied as usual. Even ten years after the verdict, GSK denied that paroxetine can cause homicide or suicide, and that there may be withdrawal problems.[367]

How to harm people from birth with a depression pill

Depression pills should be avoided during pregnancy, as they can cause miscarriages, birth defects, and behavioural abnormalities in the newborn,[368] as well as other serious harms in the offspring.[369]

The textbooks were inconsistent, confusing, and misleading; they tended to put the blame on the disease, not on the pills.[370] Two books warned that depression might increase various problems, including heart malformations and neonatal complications, but what they described were drug effects. One book noted that the Board of Health recommended always to consider psychotherapy for pregnant women who are depressed, but it advised that pregnant women who had been depressed earlier should be treated *prophylactically* with depression pills to reduce the risk of relapse from about 70% to about 25%. It is impossible to justify this recommendation, and the miraculous effect doesn't exist.

The Board of Health seemed to have gone mad.[371] They recommended routine screening of pregnant women for depression and subsequent pill treatment, even though the evidence went against this. They acknowledged that SSRIs increase the occurrence of spontaneous abortions, decrease birth weight, likely increase the occurrence of birth defects, increase the risk by a factor of five for developing pulmonary hypertension (which is a lethal harm estimated to occur in 6–12 newborns per 1,000), and increase neonatal complications such as

irritability, tremor, hypertonia and difficulty sleeping or breast feeding. An article about this appropriately called it neonatal abstinence syndrome.[372]

A Danish cohort study of half a million children showed that SSRIs double the risk of heart septum defect,[373] which means that 1% of the treated foetuses will get a septum defect. Cardiac birth defects are what we would expect to see because serotonin plays a major role in the functioning of the heart. Some people who took diet pills that increase serotonin like SSRIs do, developed deadly valvular defects and pulmonary hypertension, and these drugs have been withdrawn from the market.[374]

The Board's recommendation for screening pregnant women and treating those who test positive with a depression pill is so absurdly harmful that I wrote a little sketch about it.[375] Psychologist Olga Runciman and I spontaneously performed it as the introduction to my lecture about psychiatry in 2013 by reading it aloud from my computer. It can be seen on the web, with English subtitles.[376]

A textbook claimed that the risks of depression and behavioural disorders are increased in 18-year-old children of mothers who are not treated during pregnancy for their depression. As this cannot be true for drugs that don't work, I looked up the cited evidence. It was a clinical guideline for the use of psychiatric drugs during pregnancy produced by the Danish Psychiatric Association, the Danish Society for Obstetrics and Gynaecology, the Danish Paediatric Society, and the Danish Society for Clinical Pharmacology.[377] With so many knowledgeable people involved, one would expect the guideline to be useful, but it was dishonest.

The guideline cited two studies. One showed that if a woman is depressed, the risk of her offspring becoming depressed is increased, but only for mothers with low education.[378] This has nothing to do with treating or not treating depression. With depressing living conditions, people tend to become depressed, in this case, both the mother and child. Moreover, the article didn't say anything about whether the women were treated or not.

The other article didn't document that untreated depression in the mother increases the risk of behavioural disorders in the child,[379] but the study authors didn't like their negative result and went on fishing expeditions in the data till they found an old boot which they presented as if it was a fish! Obviously, this is not allowed in research.

In Denmark, information about drugs was provided in a small handbook, published by the Danish Medical Association, which all doctors carried with them. It was of high quality and often recommended cheap drugs that were out of patent. We all loved "the little green one" while the drug industry hated it. In 2003, the industry succeeded in removing it, and from then on, the industry foxes were guarding the hen house.

This was a huge problem, which depression drugs illustrated.[380] Several cases of infant deaths and birth defects could possibly have been avoided if the website medicin.dk had updated their text on harms. Even though several research results from 2005 to 2010 showed that there is an association between the use of depression pills and birth defects, the editors chose up till April 2011 to recommend that the drugs "can be used by pregnant women." In 2010 and 2011, the Danish Medicines Agency warned several times about the danger of deformities, without medicin.dk changing the text. A journalist revealed that the editor, physician Court Pedersen, had shares in Lundbeck.

Denial and abuse of power in Australia

In February 2014, I got an email from Bill Thomson, an Australian farmer whose only son James took his life at age 19 while on venlafaxine. He wanted to inform people about how

dangerous depression drugs are and asked if I would be willing to go on a lecture tour, which he offered to arrange. He had read over 20 books on malpractice by Big Pharma and said my book about organised crime[381] "shone the strongest light on the issues."

Bill wanted so much me to come that he visited me in Denmark to ensure I wouldn't back out. He was a superb organiser and spent a whole year on arranging the tour. In February 2015, I gave 17 lectures on different subjects in just 11 days at public venues, hospitals, and universities, and was interviewed for radio, TV, and newspapers in what was described by the Australasian Cochrane Centre as a whirlwind visit to Australia.[382] Bill sent me a list afterwards showing that my visit had been covered by 85 different media.

Shortly before I came, two Australian child and adolescent psychiatrists, Jon Jureidini and Peter Parry, and I published the article, *Dreams of a quick fix, gone awry*, about the tour where we noted what was wrong with psychiatry, which was driven by marketing-based medicine, not evidence-based medicine.[383]

I found the power structure in Australian psychiatry disturbing and heard many stories about how the higher-ups had prevented an open debate about issues of crucial importance. Two psychiatric professors stood out: Ian Hickie and Patrick McGorry. The latter was once "Australian of the Year", and they both have huge influence on national policies.

In 2011, psychiatric epidemiologist Melissa Raven, Jon Jureidini, two ethicists, and others lodged a complaint to the University of Sydney about a clinical trial led by Hickie. They had serious concerns about the ethics and the methodology of the trial, which investigated if sertraline could prevent depression in older people who were not depressed. The university involved two experts and claimed they had addressed the problems but refused to share the reviewers' report and other relevant documents, with the lame excuse that there was an overriding public interest against disclosure.

Raven appealed to an outside body that did not agree with the university. When the university still refused to hand over the documents, the matter was transferred to the judicial system.

There were major problems. Sertraline was abruptly stopped, and this was justified as common practice!

McGorry spearheaded equally absurd trials about using antipsychotics to prevent people who had never been psychotic from developing psychosis even though it is well known that these drugs can cause psychosis in the long run and when people try to get off them. McGorry published one such trial,[384] while another trial, of quetiapine in children as young as 15 "at risk" of psychosis, was halted after international protests.[385]

McGorry and Hickie had numerous conflicts of interest in relation to the drug industry, and other views than theirs are not welcome in Australia.

In 2014, Maryanne Demasi from the *Australian Broadcasting Corporation* (*ABC*) worked on a documentary about antidepressants and interviewed David Healy and me. We used a lot of time refuting Hickie's arguments and explaining to Maryanne why he was wrong.

Hickie teamed up with McGorry and their power was so great that when they refused to appear on camera, *ABC's* leadership cancelled the documentary. This is not a valid reason for dropping a highly relevant programme. Journalists can just say they refuse to comment.

Demasi had worked hard to get the scientific facts right, and I saw many of Hickie's emails. His denial of the facts was extraordinary. He denied that depression drugs increase the suicide risk in children and recommended Demasi read Gibbons' work (which, as already noted, is scientifically dishonest);[386] he claimed that FDA's Black Box Warning about the suicide risk wasn't justified and might have caused harm; he said suicidal thoughts are not

the same as completed suicides; he claimed that antidepressants do not cause a chemical imbalance; he rejected the fact that general practitioners don't have time for full mental health histories and follow ups (a US study showed that over half the physicians wrote prescriptions after discussing depression with patients for three minutes or less[387]); he claimed that an extensive literature showed that the drugs can prevent relapse; and he opined that the reason there was no wide debate about psychiatry was that the critique came from fringe groups.

Hickie keeps Australians in the dark but some of my talks were filmed and are available, e.g. *Mental health: overdiagnosed and overmedicated*.[388]

By refusing to appear on the TV programme, Hickie got off the hook in another matter. He knew that Demasi would ask him about his conflicts of interest in relation to a flawed review he published in *The Lancet*.[389] It was about melatonin-based depression drugs, but "In particular, we highlight agomelatine," which got four pages, whereas four other drugs only got one page in total. Both authors had numerous ties to Servier that sells agomelatine. They claimed that fewer patients relapsed on agomelatine (24%) than on placebo (50%), but a systematic review by other psychiatrists found no effect on relapse prevention, no effect on symptoms, and none of the negative trials had been published.[390] Three pages of letters – which is extraordinary – in *Lancet* pointed out the many flaws in Hickie's review.

I described these issues in my first psychiatry book, and they were also mentioned in the article, *Cochrane co-founder savages Aussie psychiatrists*.[391] Hickie and McGorry were asked to comment but refused. Jane Roberts wrote on the website that "The whole approach of Australia to 'mental illness' has gone loony. It is now a badge of pride to be in the 'I have a mental health problem' basket – 'can't work,' 'not responsible for my actions' – 'please give me a disability pension for life.'" Dermatologist Samuel Zagarella, who had arranged a talk for me in Sydney for his colleagues, wrote that it's impossible to learn the facts by going to lectures run by conflicted psychiatrists and drug companies and that every medical student and practicing doctor should read my two books, *Deadly medicines and organised crime* and *Deadly psychiatry and organised denial*.

In 2024, Hickie said to *ABC* that when the usage of antidepressants goes up, suicide and suicide attempts in the populations go down; that depression is a biological disease that leads to social problems, not the other way around; and that depression drugs and ECT are "wonderful treatments."[392]

Australian psychiatrist Niall McLaren told me that his specialty has all the trappings of a money-making cult based on ideology rather than science. This is also how people describe Scientology. It is taboo for the media to challenge the cult's beliefs. A reporter who did this said she would never do it again and was threatened with dismissal. Why? Because drug companies and medical lobbies immediately get on the phone to the Minister of Health and complain loudly saying it will harm patients to suggest that the drugs may harm them. This is one of the many signs that psychiatry is a cult.

Ordinary Australians are smarter than Hickie. In a large survey, people thought that antidepressants, antipsychotics, electroshocks, and admission to a psychiatric ward were more often harmful than beneficial.[393] This agrees with the best evidence we have, but the social psychiatrists who did the survey were dissatisfied with the answers and argued that people should be trained to arrive at the "right opinion." How? By more brainwashing by psychiatrists like Hickie?

When the "customers" don't agree with the salespeople, the providers are usually quick to change their products or services. This doesn't happen in psychiatry with its monopoly on

treating patients with mental health issues, or with family doctors, as the complacent frontline sales staff who do not ask uncomfortable questions about what they are selling.

3 Anxiety

In my first psychiatry book,[394] I describe eight tragic suicides the relatives wanted me to write about to warn others of the dangers of depression pills. None of the patients were depressed. The pills were prescribed because of anxiety regarding work or schoolwork (3 people), break-up with a girlfriend (2), trouble sleeping (2), and not feeling well psychologically (1). Thus, they all suffered from anxiety in some form. Unfortunately, the pills have been approved also for anxiety.

In one of the cases, the Danish general practitioner added false information to the clinical record after the patient had hanged himself while taking sertraline. I have heard much about this type of crime – obstruction of justice – where doctors changed facts that would look bad in a court case.

When I launched the book at an international meeting in Copenhagen in 2015, five of the eight women heard about it and came at their own expense to talk about their losses. There was total silence while they recounted their shocking stories, which I have uploaded.[395]

Even though the textbooks often advised psychotherapy for anxiety disorders, they also routinely recommended depression pills, especially if the condition was severe, including for children. This is the standard script for psychiatry. Those who are most severely affected, whether it be with depression, anxiety, or psychosis, get pills.

Shyness should not be treated with drugs, but when the drug companies dubbed it "social anxiety disorder," which sounds like a real "disease," the pool of patients went up from about 2% to 13% - one in every eight people - handsomely helped by the foolish diagnostic criteria that broadened over time, and by PR firms and corrupt psychiatrists and patient organisations.[396] One book noted that benzodiazepines should not be used long-term due to dependence, and because abstinence symptoms can be difficult to distinguish from the primary anxiety symptoms. Unfortunately, none of the textbooks said this about depression pills, although they cause the same problems as benzodiazepines.

Another book noted that SSRIs and cognitive behavioural therapy should be combined to get the best results in Obsessive-Compulsive Disorder (OCD) and that most studies had shown remission in 60% of the patients - a meaningless statement, as we are not told what the effect was in the placebo group. A third book contradicted this, noting that, according to the Board of Health,[397] the effect is not increased by adding pills to psychotherapy.

Anxiety should be treated with psychotherapy. A large trial of patients with social phobia showed that gradual exposure to the feared symptoms outperformed the group that got sertraline.[398] This was as expected. People on drugs don't learn anything about how to cope with their anxiety. Taking a drug is like alleviating the tension with alcohol. In contrast to drugs, psychotherapy has enduring effects on psychiatric disorders.[399]

Short-term results are likely to be misleading. It takes time for psychotherapy to work. We also need to consider that the trials have not been effectively blinded, neither for psychotherapy nor for drugs. The prevailing belief in the biomedical model of mental disorders would be expected to bias the outcome assessments in favour of drugs, and in large trials, some psychiatrists will likely not know how to provide optimal psychotherapy.

A Cochrane review of trials in children and adolescents with anxiety showed large effects for cognitive behavioural therapy.[400] The outcomes were assessed blindly in 32 of the 41 trials. The odds ratio for remission, compared with waiting list controls, was 8, and the

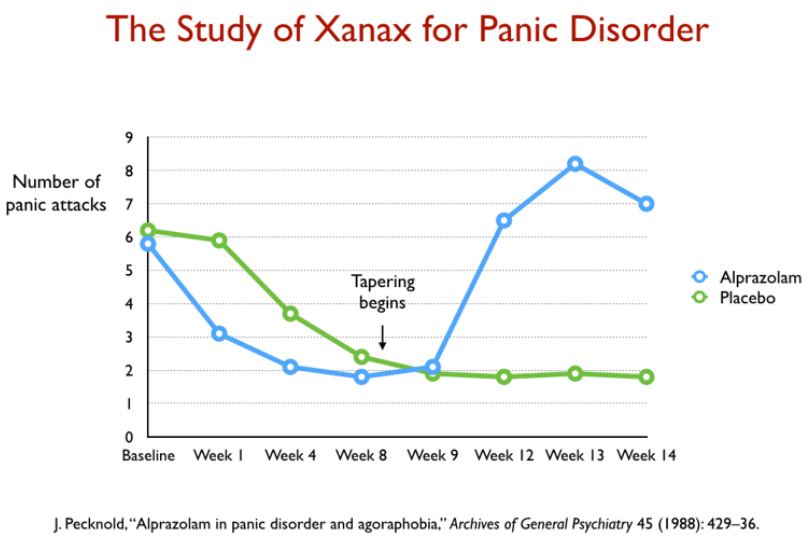
reduction in anxiety symptoms had an effect size of 0.98. Other psychological therapies were similarly effective.

A Cochrane review of any kind of psychological treatment for anxiety and depressive disorders reported similar results for paraprofessionals as for professionals (psychiatrists or psychotherapists).[401] These results agree with those from numerous other studies.[402] Patients can also help themselves. A Cochrane review of self-help where printed materials, audio or video recordings, computers, or the Internet were used to teach adult patients behavioural or cognitive behavioural therapy for anxiety, found a considerable effect compared with no intervention (effect size 0.67).[403]

For OCD, the evidence for psychotherapy is also strong. A Cochrane review of trials in adults found that psychotherapy resulted in far fewer symptoms than if the patients had received treatment as usual (effect size 1.24).[404] The effect of SSRIs in another Cochrane review was much smaller (effect size 0.46, my calculation).[405] There were few direct comparisons, but a Cochrane review found that psychotherapy was better than depression pills (effect size 0.36, my calculation).[406]

Three textbooks were dangerous for the patients. In one,[407] the authors claimed the following: about half the patients with OCD will achieve remission on depression pills; there is extensive evidence for the effect of SSRIs; we should try another pill or increase the dose beyond the maximum if the effect is insufficient; and we could also add a small dose of a psychosis pill, which was claimed to be effective "according to clinical experience." Curiously, the authors noted that the Board of Health had stated that no clinically relevant effect had been shown; that there was risk of harms; and that, in some cases, psychosis pills can cause or worsen OCD.[408] So, these authors felt that clinical experience is more important than advice from the Board of Heath!

Another book recommended SSRIs in severe cases of OCD and stated that psychosis pills could be used too.[409] It also offered horrible advice about benzodiazepines. It noted that a study had found an effect after years of treatment, especially with alprazolam and clonazepam, but that generally only a few weeks of treatment are recommended when treatment with a depression pill is started.



J. Pecknold, "Alprazolam in panic disorder and agoraphobia," *Archives of General Psychiatry* 45 (1988): 429–36.

(courtesy of Robert Whitaker)

Alprazolam is a particularly harmful benzodiazepine. After a few weeks, many people become dependent, and the rebound effect when it is stopped is so pronounced that the patients end up worse than when they started this drug (see the figure).[410]

The third book was also misleading.[411] The authors recommended long term use of benzodiazepines for anxiety and panic attacks when cognitive behavioural therapy or depression pills did not have sufficient effect.

The first book made the same recommendations and, like the second book, also recommended pregabalin, arguing that the side effects are relatively mild.[412] It is bad medicine to use antiepileptics for anxiety. According to the package insert for pregabilin (Lyrica),[413] they double the suicide risk and have many other serious harms, including life-threatening swelling of the throat, hypersensitivity reactions, weight gain, dizziness, somnolence, blurred vision, abnormal thinking (primarily difficulty with attention and concentration), and seizures if the drug is rapidly discontinued.

In 2014, the chair for the Danish OCD association, Bettina Broni, argued that the patients should take antidepressants and should ignore the tragic stories about people who had committed suicide while on SSRIs.[414] She claimed that the drugs protect against suicide, including in children, and falsely argued that to ask a patient with OCD not to take an SSRI would be the same as asking a diabetes patient not to take insulin.

Her article looked like it had been written by Lundbeck. I was allowed to comment in their members' journal, and I explained why depression drugs should be avoided in children and young people.[415]

My comments induced a former patient write her story, which is typical.[416] Aged 16, with severe OCD, her psychiatrist gave her a pill saying it would stabilise serotonin in the brain. Six months later, she had suicidal thoughts. Six years later, she was still drugged, but her psychiatrists were only interested in renewing her prescriptions. She persuaded her fourth psychiatrist, however, to taper off the drug, and then she noticed for the first time in years, the beauty and joy of birdsong. The happiness she felt was indescribable. She hadn't made any progress before she stopped the pills and declared war on OCD, helped by her psychologist. Another psychologist told me his name had been deleted from the list of therapists at the OCD association; he suspected it was because he was against drugs.

If you suffer from anxiety, you should not see a psychiatrist. Anxiety is often the entry ticket to psychiatry, with subsequent additional diagnoses, polypharmacy, a ruined life, and death for some patients. A doctor, who had an emotional crisis and lost seven years to psychiatry because of serious medical malpractice committed by her psychiatrist, wrote: "One day, it was like the penny dropped and I laughed out loud when I realised that I had been prescribed medication to treat my psychiatrists' anxieties. They should have been the ones taking my pills."[417]

In 2023, I published the article, *Psychiatry killed Tuva Andersson, whose problem was anxiety*.[418] Her mother contacted me, as she felt there had been no justice. It is a harrowing story. Tuva was a victim of malpractice stemming from professional incompetence and gross medical negligence. She felt stigmatised by a variety of ever-changing, nonspecific diagnoses, and was exposed to forced treatment. This included a depot injection of a neuroleptic from which it was impossible for her to withdraw. During the last year of Tuva's life, her psychiatrists took away all hope of recovery.

She was only 37 years old when she killed herself with two of the drugs she had been prescribed, amitriptyline and zopiclone.[419] A local newspaper, Hudiksvall Tidning, stated:

“The personal disaster that befell this family involves so many mistakes in the chain of care that it is mind boggling. How is that even possible, one thinks when reading the story of Tuva. Everyone can make the wrong decision at some point. But not all the time.”

Unfortunately, in psychiatry, people make wrong decisions all the time.

Two of my friends, Steven Woloshin and Lisa Schwartz (died in 2019) from Dartmouth in the USA showed that if patients are told the facts, they are much better at choosing a good drug or no drug and in knowing what the benefits and harms are.[420]

If people knew that the effect of sleeping pills is to make them fall asleep 15 minutes faster,[421] and to make them dizzy and drowsy the next day, they might be less interested in taking them, and if they also knew that the effect disappears within two weeks if they take them every night, few people would become addicted to them.

Steve and Lisa convinced the FDA’s Risk Communication Advisory Committee that the agency should adopt their suggestions. However, after having thought about it for a year, the Department of Health and Human Services announced it needed at least three more years to come to a decision.[422] An initiative that indisputably helps patients to choose rationally between drugs, or even to say no to drugs, seems to be viewed almost as an attack on the state. It could lead to loss of income for the drug industry and the many people it corrupts.

It is now 13 years ago that the government needed another three years to think about this excellent initiative, and the FDA stalled. Nothing happened. No wonder some call it the Foot Dragging Agency.

4 ADHD

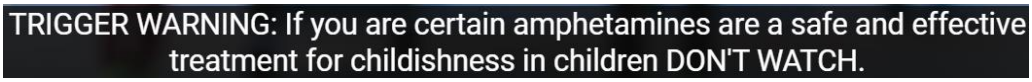
I have covered two disaster areas in terms of the diagnoses, clinical research, and the harms inflicted on many millions of healthy people and here is a third disaster area: Attention Deficit Hyperactivity Disorder (ADHD).

Patients and their relatives often refer to ADHD drugs and depression pills as "Psychiatry's Starter Kit." Many people start their psychiatric "careers" by consulting their family doctor with some problem many of us have from time to time and get a prescription, which starts a chronic course with multiple diagnoses and drugs and deterioration.

ADHD was invented in America. Joseph Biederman, who sat on the DSM-IV committee, did a lot to promote the diagnosis and get it included in the manual.[423] It later emerged that, in just five years, Biederman received fees from more than 24 drug companies, and Janssen alone gave him over one million dollars.

No one knows what ADHD is,[424] and there is a good reason for that. It doesn't exist as a concrete thing but is just a name for people at one end of a normal behavioural spectrum who are more energetic and irritating than others. Obviously, we cannot all display average behaviour. At one end, we have people who are more active who get an ADHD diagnosis. At the other end, we have those who are quieter than average who get an Attention Deficit Disorder (ADD) diagnosis. Maybe we shall also one day see a diagnosis for those in the middle: Activity Normal Disorder (AND), and these people too are surely also in need of drug treatment.

There is a very funny video that mocks the ADHD pseudoscience and shows how absurd it all is.[425] It starts with this:



Methylphenidate (Ritalin) is the modern version of the cane. We are no longer allowed to beat noisy children but are allowed to alter their brains with a narcotic on prescription (most ADHD drugs are either amphetamine or related substances). We medicalise the inevitable conflicts and difficulties that arise between children and their parents or other adults and blame them on a neurodevelopmental disorder or a brain disease although no one has shown that the brains of people so labelled is different to that of others,[426] which the latest revision of the diagnostic manual, DSM-5-TR, explicitly acknowledges.

To postulate that hundreds of millions of people have wrong brains is as outrageous as it gets. It is a flagrant abuse of a faulty disease model.[427] I googled "what causes ADHD" and found this misinformation from the UK National Health Service:[428]

"ADHD tends to run in families and, in most cases, it's thought the genes you inherit from your parents are a significant factor in developing the condition … Research has identified a number of possible differences in the brains of people with ADHD from those without the condition … Other studies have suggested that people with ADHD may have an imbalance in the level of neurotransmitters in the brain." *All* of this is plain wrong.

I have heard many professors of psychiatry say that genetic factors are the most important causes of ADHD. Per Hove Thomsen noted that genes can explain 80%,[429] and Kerstin Plessen said that there is 80% agreement for identical twins.[430]

So, people who are identical are pretty much identical also when it comes to behaviour. Surprise, surprise. But if we look for genetic abnormalities, we don't find anything. In one

study, which claimed ADHD was related to this, combining two tables shows that 99.7% of the patients don't have genetic abnormalities.[431]

Many children qualify for the diagnosis because they are talented and cannot sit still in poorly disciplined and boring classrooms, or because they have emotional problems generated at home. A family doctor told me that a schoolmistress had sent most of her pupils for examination on suspicion of ADHD. It was clearly she who was the problem, but as soon as the kids are branded with ADHD, it relieves everyone of any responsibility or incentive to redress the mess they have created, whether at school or at home. It also increases inequality. ADHD drugs are prescribed much more if the parents have low-skilled jobs.[432]

A Canadian study of one million school children showed that the prevalence of children in drug treatment in the same class increased in a linear fashion over the calendar months,[433] and 50% more of those born in December were on drugs than those born in January. Thus, if we allow the children to grow up and mature, fewer will receive diagnoses and drugs.

Finnish psychiatrist Ben Furman has developed a fascinating programme, Kids'Skills,[434] which is about teaching kids with difficulties various skills to manage their emotions and behaviour better and make them proud of their achievements.

When I lecture, people sometimes say they have ADHD. I reply they can have a dog or a car but not ADHD, which is just a name. When we give a certain behaviour a name, we cannot say that a person behaves this way *because* he has ADHD. This is circular evidence. Unfortunately, the psychiatrists talk about their social construct, as if it existed in nature and can attack people like bacteria can, e.g. the authors of the adult ADHD checklist noted that adult ADHD can have a significant impact on relationships, careers, and safety of the patients suffering from it.[435] In 2024, a newspaper applauded that more and more middle-aged and older people got diagnosed and noted that they have to "live with ADHD."[436] You can live with a cancer, which really exists, but "living with ADHD" just means living with yourself, which we all do, so this is an empty statement.[437] The article noted that the diagnosis provides an explanation for people, which is impossible, as it is just a name.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date					
Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.			Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?							
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?							
3. How often do you have problems remembering appointments or obligations?							
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?							
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?							
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?							
							Part A

During my lectures, I have often asked the audience to test themselves with the diagnostic criteria for adult ADHD, which are so foolish that 25–50% test positive. Once, 21 of 27

therapists tested positive and 10 had a full house (six out of six criteria; only four are needed for the diagnosis). I told them not to worry because some of the most talented and wonderful people I have met are like that. My wife and I and our youngest daughter also tested positive, as did her very laid-back boyfriend. You might want to try the silly test on yourself. If you land in the grey area four times (see the table above), you "have" ADHD.

In 2004, the New York University School of Medicine Adult ADHD programme offered a free screening day at a hotel and found that 85% of adults tested positive.[438] When only half of them had contacted a doctor subsequently, the director of the programme said the data showed that "people with ADHD need help to get help." Stupidity has no limits.

The stigmatisation and loss of self-esteem, which often follows a psychiatric diagnosis, is especially ominous in children who have yet to shape their personalities. They may learn to view themselves as disabled, with impaired self-determination and increased feelings of helplessness.[439]

One of my colleagues, UK child and adolescent psychiatrist Sami Timimi, asks parents who believe that an ADHD drug will help their child, what changes they are hoping to see and what their concerns are, e.g. behaviour at home, peer relationships, academic performance at school, or a lack of a sense of danger. He might then say that no drugs can alter these things in their child. Drugs don't make decisions, have dreams and ambitions, or perform actions.

This way, Sami diverts the parents' interest from drugs to developing parental management skills for children who are more "intense" than most. A UK documentary showed children, which were so difficult to deal with that even critical psychiatrists might think ADHD drugs are necessary. "We cannot have children hanging around in the curtains," as a child psychiatrist told me at a hearing in Parliament. However, the families got help from psychologists and learned that the children were disturbed, which was why they were disturbing. A mother who always reprimanded her "impossible" daughter was taught to praise her instead, and she developed into a very nice child that was no longer hostile towards her mother.

The ADHD diagnosis should not be a prerequisite for getting extra help or money for schools, as it increases the prevalence of the diagnosis. But doing the right thing in psychiatry is difficult. An Irish child psychiatrist told me he was suspended because he didn't put children on psychiatric drugs. Instead of changing children's brains, we should change their environment.

Sexual abuse of children is frighteningly common. According to posts on the Internet, about one in ten children are sexually abused. About half of the women at psychiatric hospitals have been sexually abused as children or adolescents, and in most cases, hospital staff are unaware of this.[440]

If a child behaves badly, is provocative and defiant, this can lead to a diagnosis of ADHD or borderline personality disorder, although it might be a reaction to a horrible abuse the child doesn't dare talk about. Not even when the patients do talk about it, it is always being taken seriously. A young woman told me that she noted to her psychiatrist that she had been sexually abused as a child. He replied that it was beside the point. All that mattered to him was the questionnaires he used for making diagnoses. Many patients have told me it took many years before they met a psychiatrist who took an interest in the serious trauma, they had experienced.

The indoctrination of psychiatrists is effective. In 2022, one of my colleagues lectured in critical thinking for psychiatry residents. He asked them to review three studies claiming that kids with an ADHD diagnosis had genetic abnormalities or smaller brains than other kids.[441]

The residents emphasised that the genetic differences were highly significant and said that the brain volume study suggested that ADHD was a neurodevelopmental disease.

My colleague was flabbergasted. When he explained that their views were not supported by the studies they had just read, they became hostile. Didn't he understand that ADHD and other psychiatric disorders were biological disorders, like diabetes or cancer?

This was the most hopeless insanity in psychiatry he had ever experienced. It is frightening that such people are supposed to take care of psychiatric patients in an evidence-based fashion. They are unable to do this, as it requires a minimum understanding of science.

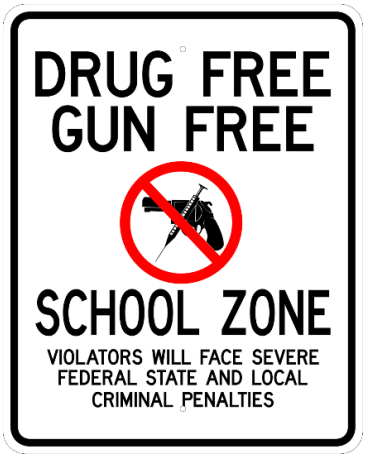
The study claiming that children with an ADHD diagnosis have small brains has been widely condemned. The researchers wrote that their study sends a "clear message for clinicians to convey to parents and patients, which can help to reduce the stigma that ADHD is just a label for difficult kids and caused by incompetent parenting."[442] This nonsense is heart-breaking. It does *not* reduce stigma to tell people they have small brains. *Lancet Psychiatry* devoted an entire issue to criticisms of the study, and a re-analysis of the data found no brain differences.[443]

As usual for psychiatry, the Americans are worst. The American Academy of Child and Adolescent Psychiatry writes on its homepage that ADHD is a brain disorder and that scientists have shown that some structures in the brain in children with ADHD can be smaller than those areas of the brain in children without ADHD.[444]

Narcotics on prescription

In 2011, my wife and I got very angry when an ADHD bus visited our youngest daughter's school and distributed brochures to "raise awareness of the ADHD disorder in children." It was all about pushing drugs. The bus was owned by the Danish ADHD Association, which received financial support from companies selling the drugs and producing brochures. The director of the ADHD Association was hired because of her "commercial orientation," with a focus on establishing "partnerships with private companies."[445] Absolutely disgusting.

In the USA, you can be met with this warning:



But there are no drug free schools in America where over 10% "have" ADHD and are on speed.[446] It is a paradox that teachers act as more effective drug pushers than those in the streets. Particularly because schoolteachers have observed that exercise makes the children calmer and more attentive. The effects are huge. A review of the trials found an effect size of 0.92 for improved inattention, 0.82 for inhibitory control and 0.52 for cognitive flexibility in youngsters with an ADHD diagnosis.[447]

The short-term benefit of the drugs is that children may sit still in class, but the effect disappears quickly, and the harms include tics, twitches, reduced spontaneous mental and behavioural activity, reduced social interest, apathy, indifference, and depression and compulsive, meaningless behaviours, which animal studies have confirmed.[448] The compulsive behaviour is often misinterpreted as a benefit even though the child may just obsessively copy everything shown on the board.

There seems to be no long-term benefits from ADHD drugs. In 1999, the US National Institute of Mental Health (NIMH) published 14-month results of the first long-term trial, the MTA study, in which 579 children were randomised to methylphenidate, behavioural therapy, both, or routine community care.[449] Even though many scales and outcomes were used, with 19 primary outcomes, the only drug effect was that the children were less hyperactive or impulsive and paid more attention.

The authors considered ADHD a chronic disorder (which they contradicted in their next publication) and advocated ongoing treatment, which agreed poorly with their results. The differences in scores did not translate into anything important, but the psychiatrists weren't eager to reveal this. It took another *eight years* before they published the three-year data, which showed no differences.[450] A companion paper was difficult to interpret, as the findings were drowned in complicated statistics. This time, the investigators revealed their financial conflicts of interest, which were excessive: on average, 13 drug companies were listed per author, not a credible bunch of people. The limited relevant data there were showed a *higher* rate of substance abuse in the methylphenidate group than in the behaviour therapy group.[451]

This was expected, as narcotics increase the risk of substance abuse. But a unique study that confirmed this wasn't published. The main investigator, Nadine Lambert, died in a car accident in 2006[452] and maybe her colleagues didn't like her results. Lambert did a 26-year study of 492 children, half of whom had an ADHD diagnosis.[453] Only 2% of those who had never smoked or taken stimulants were dependent on cocaine as adults, compared to 40% of those who both smoked and were treated with stimulants. It was not a randomised trial, but her results were so threatening for the establishment that, after she had presented them in 1998, the National Institute on Drug Abuse stopped funding her work.[454]

The six- and eight-year results of the MTA study were also discouraging.[455] There were no differences for school grades, arrests, psychiatric hospitalisations, or other relevant outcomes. The use of trial drug had decreased by 62% but adjusting for this didn't change the results.

I have an extensive background in statistics. When I did my thesis, I read two heavy textbooks[456] ensuring I understood everything in them. I recalculated all the examples on a pocket calculator (I didn't get a computer before 1987). I have even done three-way analyses of variance on my pocket calculator.[457] I can therefore say with great confidence that the follow-up papers looked like deliberate obfuscation using unnecessarily complicated stati-

stics. It would have been much easier to honestly describe the disappointing results, but none of the over 100 scientific papers the MTA study generated did that.

One of the investigators broke ranks and stated in an interview:[458] "The children had a substantial decrease in their rate of growth ... there were no beneficial effects – none ... that information should be made very clear to parents."

It wasn't. Just like everywhere else in psychiatry, the public was duped, seduced, and lied to.[459] A news release issued by NIMH presented a huge lie: *Improvement following ADHD treatment sustained in most children*. One of the authors, Peter Jensen, said, "We were struck by the remarkable improvement in symptoms and functioning across all treatment groups." And rather than saying that the growth of children on drug treatment was stunted, the press release said that children who were *not* on medication "grew somewhat larger."

The drug industry deceives people in the same way. When Merck found out that its arthritis drug, rofecoxib (Vioxx), was deadly and caused more thromboses than naproxen, they invented the hoax that naproxen was protective rather than Vioxx being harmful, which nonsense the *New England Journal of Medicine* allowed Merck, a US company, to publish.[460]

The stunting of growth caused by ADHD drugs was huge. After 16 years, those who consistently took their pills were 5 cm shorter than those who took very little, and there were many other harms.[461]

Based on what we know about other brain active substances,[462] and the fact that ADHD drugs reduce mental activity and interaction with other people, which are important for brain development, it seems likely that ADHD drugs may harm the brain permanently.

Danish child and adolescent psychiatrist Lisbeth Kortegaard and US psychiatrist Peter Breggin have gradually withdrawn ADHD drugs from every child that came their way and have both experienced that it improves the child's condition given the parents agree and work on improving their parental skills. Lisbeth has stopped psychiatric drugs in many children and has never seen anyone who deteriorated.[463] I know both of them and Breggin, with whom I have lectured several times, believes we should prohibit giving psychiatric drugs to children, just like we have prohibited physical and sexual abuse.[464] I agree drugging children should be prohibited, with very rare exceptions.

Psychiatrists lie profusely about ADHD drugs. They write and say that methylphenidate protects against crime, delinquency, and substance abuse. They even said this at a hearing in Parliament on 27 May 2013, which I rejected. They were highly dissatisfied that I, as the only speaker and not being a psychiatrist, had been asked by the politician who organised the meeting, to give two talks. Lisbeth also lectured. We succeeded to make another child and adolescent psychiatrist, Tine Houmann, very angry because she didn't get away with her lies.

The WHO has refused to grant methylphenidate the status of an essential medicine. In 2023, some clinicians and scientists echoed drug company parlance when they wrote in *Lancet Psychiatry* that this was a wrong decision arguing that the drug has a proven track record of efficacy and safety.[465] We explained why they were wrong and the WHO was right,[466] and my research group has shown that FDA's approval of Purdue's controlled-release methylphenidate for adult ADHD was inappropriate, as the drug did not produce any meaningful clinical benefits.[467]

The psychiatric textbooks direly warned of the consequences if ADHD is not treated with drugs and they were full of false claims that ADHD drugs improve educational and occupational outcomes and reduce the risk of accidents, emergency visits, crime, and drug abuse.[468]

One book claimed there is no evidence that psychotherapy works on the "neurologically conditioned core symptoms" and that the few large studies of psychotherapy all have methodological problems, citing a book by psychiatrist Marianne Geoffroy whose denial of the facts and lack of logical thinking I described in the chapter on depression. This is false. A Cochrane review of 14 trials of psychotherapy showed an effect on core symptoms.[469]

One book noted that a Cochrane review raised doubt about the effect of methylphenidate but added that many clinicians and patients say they have experienced that methylphenidate works, which is indisputable. Great, then why bother to do randomised trials when we can just ask what the psychiatrists believe?

Claims that placebo-controlled studies have shown an effect of stimulants in 70–80% of the children are idiotic, as they ignore the spontaneous improvement in the placebo group that would have occurred without any treatment at all. Huge effect sizes in adults were also claimed. A Cochrane review – that it took nine years to produce after the protocol was published - showed some positive effects, but the results varied so hugely that it was wrong to meta-analyse them, and the authors could not determine if adverse effects did not occur or if the data had not been collected. The review was so bad that the criticism we[470] and others raised led to its withdrawal from the *Cochrane Library*.

Two Cochrane reviews performed by my employees found that every single trial ever performed of methylphenidate was at high risk of bias.[471] When given to adults, the drug had no effect on days missed at work, in contrast to what was claimed in the textbooks.

Many of the studies were rigged, either by dropping all children who improve on placebo before the trial starts, or the opposite, studying only children who have tolerated the drug before they are randomised to drug or placebo, or both.[472] The industry calls this an "enriched design." I call it a design that makes the industry rich.

The drug regulators are remarkably gullible and uncritical. We showed that trials were missing in 7 of 13 applications for approval of extended-release methylphenidate for use in adult ADHD even though regulators require that all trials must be included in new drug applications, and the median proportion of missing trial participants was 45%.[473]

One textbook spoke of quick and dramatic drug effects and noted that studies based on registers suggested a long-term effect on learning, marks, and schooling. There were 19 references but no discussion of the MTA trial that annulled the wishful thinking. It also advised to continue with drugs for as long as there is clinical effect, and the harms are tolerated. It is impossible to judge if there is any benefit in an individual case, and the trials speak against treating people for years, but the MTA trial was not among the 11 references.

Another book claimed that drugs improve social interaction, alleviate aggression, have a moderate to large effect, and reduce the risk of drug abuse. The authors cited the MTA study but only in a figure about co-morbidity. The MTA paper in their literature list was 20 years old and only reported the misleading 14-month results.

The authors provided three more references, to totally unreliable research.

One was a meta-analysis of 28 placebo-controlled trials where the authors used a home-made quality score for assessing the quality of the trials,[474] a method firmly recommended against.[475] They reported a huge effect on aggression, effect size 0.84, which is stunning, as we know that stimulants *cause* aggression![476]

The second reference was to an editorial claiming that ADHD drugs reduce the risk of substance abuse.[477] The author's numerous financial conflicts of interest was dismissed by the editor who had "found no evidence of influence from these relationships." It is funny how people always deny the fact that drug company money corrupts. The author com-

mented on a study of health care claims from 3 million people, which is not reliable evidence. He noted that a 2003 meta-analysis found a two-fold reduction in the risk of substance abuse but didn't provide a reference to this obviously erroneous result. I was unable to find it even though I browsed hundreds of records. And he did not cite the MTA trial of course.

The third reference was to an exceptionally flawed meta-analysis even by psychiatric standards.[478] The authors included only 12 of the numerous existing trials and reported huge effect sizes, 0.96 and 0.73, without explaining which outcomes they came from. They translated these effects to binary data and reported that the number needed to treat to benefit one patient was about 2–3, which is impossible. It is a no go to dichotomise continuous variables.[479] The first author had "Potential conflicts of interest" related to companies selling ADHD drugs. Conflicts of interest are not potential; they are real.

It is popular in psychiatry to blame the victim. A textbook noted that, in *high* doses, the drugs may trigger or aggravate depressive and psychotic symptoms if the patient is *predisposed*. Such symptoms may occur on usual doses and without any predisposition.

The author, child and adolescent psychiatrist Søren Dalsgaard, provided two references to his own observational studies, and they were not illuminating. One noted that children with ADHD had criminal convictions in adulthood five times more often than the general population.[480] What are we to make out of that? We cannot reduce crimes by using drugs. Dalsgaard did not mention the MTA trial, and his other study was even worse.

He noted that for every year drug treatment was postponed in children, the risk of drug abuse increased by a factor of 1.5.[481] Thus, the risk of drug abuse is 130 times higher (1.5^{12}) if a child starts treatment at age 18 rather than at age 6. I calculated from the article that the background rate in the population is 0.69%. Thus, 0.69% x 130 = 90% of all children with an ADHD diagnosis from age 6 will become drug abusers if they are not treated before age 18. The article did not specify the age span that provided the data for the 1.5 times annual risk increase, and I might have extrapolated too liberally, but the study is absurd. There must have been huge confounding. Children who start drug treatment late are very different to other children.

The serious harms of ADHD drugs are ignored

We showed that ADHD drugs impair reproduction in animals even after the drugs are stopped.[482] We don't know if this is also an issue for humans, but we do know that fecundity is declining.

We found that the reporting of harms in methylphenidate trials is highly unreliable.[483] There were huge differences across trials that were impossible to explain, e.g. decreased libido was experienced by 11% in one trial versus only 1% in a pooled analysis of three other trials. As quality of life was measured in 11 trials but only reported in 5, where a tiny effect was found, quality of life likely worsens on ADHD drugs, which is also what the kids experience. If asked while their parents are not present, they say they don't like the drugs. This is not surprising. Among harms, the textbooks listed headache, dry mouth, nausea, stomach pain, tics, irritability, sadness, depression, mood swings, nervousness, worsening of anxiety symptoms, sedation, increased blood pressure, insomnia, anorexia, and weight loss.

A study of 218 Israeli young adults diagnosed with ADHD and using stimulants showed that 28% had tried to resist taking the drugs as children when told to do so by their caregivers.[484] Mood changes were observed among 66%, whereas the rate was only one per

10,000 users in the package insert for Ritalin; 39% felt they were not themselves; and 3% had had thoughts of attempting suicide. The study used closed-ended questions and there was no control group. A Cochrane review that had comparable control groups reported that methylphenidate increased the risk of serious adverse events (risk ratio 1.36), any psychotic disorder (RR 1.36), arrhythmia (RR 1.61), insomnia and sleep problems (RR 2.58) and decreased appetite (RR 15.06).[485]

The most serious drug harms received little or no attention in the textbooks. The only mention of withdrawal symptoms was in a book that noted that the symptoms can lead to decreased ability to drive, use machines and work. In contrast, a Cochrane review noted that people dependent on amphetamine can experience severe withdrawal symptoms that can last for weeks, and which include dysphoria, irritability, melancholia, anxiety, hypersomnia, marked fatigue, intense craving for the drug, and paranoia.[486]

Stimulants have hallucinogenic properties,[487] and some children develop mania or other psychoses.[488] At an FDA advisory meeting, it was estimated that symptoms of psychosis or mania "occur at a rate of 2 to 5 per hundred person-years (observed 1.6 per 100 patient years)."[489] When FDA staff analysed data from 49 randomised trials of stimulants three years later, there were 11 psychosis/mania adverse events during 743 person-years of double-blind treatment with these drugs, and none during 420 person-years of placebo exposure. Hallucinations involving visual or tactile sensations of insects, snakes, or worms were common in cases in children.[490]

In FDA's Prescribing Information for extended-release methylphenidate, the risk is stated to be only 0.1%,[491] whereas in the UK drug agency's review, psychosis or mania occurred in 3% of patients on methylphenidate (versus 1% on placebo),[492] which is 30 times higher.

The psychiatric harms often lead to additional diagnoses, e.g. depression, obsessive compulsive disorder or bipolar, and additional drugs and chronicity. The drugs also cause violence, including homicide.[493]

Andrew Thibault, co-founder of Parents Against Pharmaceutical Abuse, has described suicides by hanging in foster children with an ADHD diagnosis and in treatment with lisdexamfetamine (Vyvanse).[494] These children were used as guinea pigs in drug trials against the regulations and were massively overdosed. When a Canadian study found that youth on ADHD drugs were 13 times more likely to be prescribed antipsychotics and almost 4 times more likely to be prescribed antidepressants than other children, the authors argued that children with ADHD have more psychiatric comorbidities than children without ADHD, ignoring the obvious fact that psychosis and depression are labelled side effects of ADHD drugs in package inserts.

One textbook noted that the drugs can cause mania and destabilise bipolar disorder, but not that bipolar is often misdiagnosed because of the drugs' harms. In 2015, I was invited to lecture at Aalborg Hospital by the psychiatric organisation in the region and Rasmus Licht, a professor of psychiatry, lectured after me. He is a specialist in bipolar disorder, and I asked him how he could know, when he made the diagnosis in a patient who received an ADHD drug, that it was not just the drug harms he saw because they are very similar to the symptoms doctors use when diagnosing bipolar. I was flabbergasted when he said that a psychiatrist was able to distinguish between these two possibilities. Rasmus in wonderland …

Psychiatrists usually ignore this fundamental problem and may even say that the drug treatment has "unmasked" the new disorder. This is one of the reasons why contact with the psychiatric system often leads to several diagnoses and polypharmacy and why temporary problems with mental health often become chronic. I call this the fly paper of psychiatry. The

more noise the patients generate by flapping their 'wings,' the more stuck in diagnoses and drugs they become.

Many patients refrain from telling their psychiatrist certain things to avoid even more diagnoses and drugging. When asked if they have become better, they may confirm this even when the opposite is true. They quickly learn how to behave to protect themselves.

In the end, no one can remember how it all started and what life was like before the patient got a diagnosis. Patients become chemically induced, artificial products with brains and personalities that are no longer the same. And drug use becomes part of their identity - just as it is for drug addicts.

It should be forbidden to make new diagnoses in patients on psychiatric drugs. If people get admitted to hospital in a psychotic state because they have taken cocaine, LSD or marihuana, we should not say: "Great, the drug has unmasked your schizophrenia!"[495] Unfortunately, many psychiatrists think this way.

One textbook mentioned that abstinence reactions after stopping an ADHD drug abruptly can include depression, but even though the authors stated that the depression could come suddenly and cause a great risk of suicide, they gave the deadly advice to treat the depression with depression pills, increasing the suicide risk further. The correct approach is to reintroduce the ADHD drug and taper it off slowly.

ADHD drugs are easily available on the black market, and the WHO has warned about amphetamine-type drug abuse, including methylphenidate and MDMA (ecstasy), and said the situation "warrants immediate attention."[496] But they did not warn that the increasing use of stimulants on prescription is also a huge problem. This is taboo even though there were 10,333 drug overdose deaths in the USA in 2017 involving stimulants, compared to only 1,378 in 2007.[497]

Drug regulators are also inconsistent. Methamphetamine is not approved in Europe where it is considered a dangerous, illegal drug like cocaine.[498] It is approved in the USA for ADHD, but the FDA warns that it has a high potential for abuse.[499] In 2023, the FDA warned that stimulants can lead to development of substance use disorder and addiction even when prescribed to treat an indicated disorder, and that this can result in overdose and death.[500]

Adderall – a mixture of amphetamine salts – was a weight reduction drug called Obetrol, which was so addictive that it was withdrawn from the market.[501] Adderall is now used in the USA for ADHD but was withdrawn in Canada in 2005 after 14 children suddenly died and two had strokes.[502] The FDA did nothing, apart from trying to convince their Canadian colleagues not to withdraw the drug.

Death, the most severe harm, was never mentioned in the textbooks even though cardiac arrhythmias, myocardial infarction, stroke, and sudden death are listed in FDA's package insert for methylphenidate.[503] Stimulants double the risk of cardiovascular events,[504] and children have suddenly dropped dead.[505] That ADHD drugs can cause violence, suicide, homicide and death for other reasons[506] has also not received much attention. Psychiatrists do not think that deadly harms of their drugs are important information to convey in their textbooks to future psychiatrists.

In 2014, I was involved as an expert witness in a much-publicised court case where Graham Bishop, an Englishman, almost stabbed his two daughters to death at Rigshospitalet where I worked. He was sentenced to 11 years in prison and permanent expulsion from Denmark, but the case was appealed.

The forensic committee acknowledged that methylphenidate could lead to "increased irritability and emotional instability" and that they could not exclude the possibility that the drug could have influenced his psychological state when the act was committed. But they considered it unlikely, arguing that he had previously taken similar doses without problems.

I noted to Bishop's lawyer, Karoline Normann, that he had never taken such a high dose before as the one he took just before the crime, and that even if he had not increased the dose, he could still have reacted out of character under the influence of the drug because the events that led up to the misdeed were very stressful. Moreover, as the harms of methylphenidate are far worse than the committee's euphemistic note about "increased irritability and emotional instability," I wanted to see the committee's mental assessment of Bishop. The prosecutor refused, which I found unjust, as my role was to support the defense.

Via Normann, I asked the forensic committee if they considered it the standard of care that Bishop's psychiatrist had told Bishop that he could increase the dose without problems and with no upper limit. This question, and several others I posed, was ignored by the committee, and their reply to my question: "Does the forensic committee think that intake of methylphenidate can increase the risk of violence, including homicide?" was: "The question is of a general character."

Yes, but it was relevant for the case. I was very uncomfortable about not getting answers and about the committee being in a position where it was essentially asked to evaluate its own previous judgment. This is an unacceptable conflict of interest, as few people are willing to admit their mistakes and overrule themselves.

No one knows if Bishop would have committed his hideous crime had he not been on methylphenidate. Normann recently told me that he is completely normal today and that his surviving daughter sees him (the youngest one died; she suffered from a serious disease).

This is not the only time I have seen our forensic committee behave inappropriately. In 2014 when we wrote questions to the committee, six of the ten members were psychiatrists, including Poul Videbech who, as I explained in the chapter on depression, is unpredictable, arrogant, and unable to interpret science correctly.

The committee's verdict is cut in stone, as if they were the Oracle of Delphi; no judge dares question it; and it cannot be appealed. This is highly problematic, considering that psychiatrists routinely deny the most dangerous harms of psychiatric drugs, particularly suicide and homicide.

Des Spence, a general practitioner from Glasgow, has explained how psychiatry has become big pharma's goldmine and how it exploits children with ADHD drugs:[507]

Seek a small group of specialists from a prestigious institution (Harvard). Big pharma becomes the kingmaker, funding research for these specialists. Report about underdiagnosis and undertreatment, never the opposite. Control all data and make the study duration short. Use the media, plant news stories, and bankroll patient support groups. Pay your specialists large advisory fees. Lobby government. Get your specialists to advise the government. Now the world view is dominated by a tiny group of specialists with vested interests. Use celebrity endorsements to sprinkle on the marketing magic of emotion. Expand the market by promoting online questionnaires that loosen the diagnostic criteria further. Make the illegitimate legitimate.

A small Harvard group admitted undisclosed personal payments from drug companies totalling $4.2 million. Joseph Biederman and his Harvard colleagues underreported their earnings to university officials; each of them had made over a million dollars from drug

makers during only eight years. And the drug industry accounted for about 30% of the $63 million in financing the American Psychiatric Association in 2006.[508]

For a European, $63 million for financing a specialist organisation in just one year is like living on another planet. What do they use all that money for?

A review of 43 drug trials in children confirms Spence's kingmaker tale.[509] Very few drug reactions were called serious, although many children dropped out of the studies because of serious adverse drug reactions. Moreover, adverse drug reactions were only reported if the incidence was above 2% or 5%. I worked out how much inbreeding there was: 21 papers (49%) came from Harvard Medical School or Massachusetts General Hospital in Boston, only three miles away from the school, and Biederman co-authored 13 of them.

Biederman extorted the drug companies. Internal emails revealed that he was furious after Johnson & Johnson rejected his request of receiving a $280,000 research grant.[510] A company spokesperson said he had never seen someone so angry, and their business became non-existing within Biederman's area of control.

Biederman was handsomely rewarded for his corruption of the science. He was one of the world's most influential child psychiatrists, one of the most cited ones, was inducted into the Hall of Fame of CHADD (Children and Adults with Attention-Deficit Hyperactivity Disorder), was awarded the 2021 World Federation of ADHD Gold Medal Award for his lifetime contribution to the field of ADHD[511] and he received over $15 million in grant funding from the National Institutes of Health.

Biederman played a leading role in the destruction of children. He and his co-workers made a diagnosis of bipolar in 23% of 128 children with ADHD and reported this in the paper, *Attention-deficit hyperactivity disorder and juvenile mania: an overlooked comorbidity?*[512] There is no overlooked comorbidity, only overlooked harms of ADHD drugs that resulted in a wrong diagnosis of bipolar in about one quarter of the examined children. Bipolar in children rose 35-fold in just 17 years in the United States,[513] which is because of the loose diagnostic criteria and increased use of ADHD drugs[514] and depression drugs,[515] which may cause mania, leading to a diagnosis of bipolar disorder in one out of ten young people treated with a depression drug.[516] The fact that doctors in America make this diagnosis in children 100 times more often than in the United Kingdom[517] illustrates it is a fake diagnosis in almost all cases and the extent to which American psychiatry is corrupted.

Biederman's invention of juvenile bipolar disorder caused a huge number of children to be treated with psychosis pills. Bipolar in children was virtually unknown before Biederman started pushing the diagnosis and the drugs. A book called it "Mad science" in its title.[518]

Psychiatrist James Deutsch asked Biederman in 1998 at a conference what proportion of his "bipolar" kids that had histories of trauma. He replied without hesitation: "None." Deutsch then asked where in the world he found such patients. Biederman replied that his patients were clean of trauma but "horrendous" in behaviour. His junior colleague said that fewer than three drugs simultaneously would not have any impact on their patients. Deutch regrets he did not do more to stop the madness.

Such is the top of the psychiatric profession. Immensely rewarding for those who harm the patients the most.

A UK psychiatrist told me that an 18-year-old boy had been on lisdexamfetamine and guanfacine for 11 years without any drug holidays. Once, when there were issues with his drug supply, he developed a psychosis after missing several doses of lisdexamfetamine and was admitted to hospital. After nine months, he was still in hospital but now he was also receiving a neuroleptic, a depression drug and benzodiazepines. This drug cocktail is insane,

dangerous and illogical. Neuroleptics decrease dopamine while lisdexamfetamine increases dopamine. Unfortunately, such prescribing of antagonistic drugs is common in psychiatry.

The conclusions are clear: The ADHD diagnosis is fake and should be banned; ADHD drugs are narcotics on prescription and should be removed from the market; people with symptoms that qualify for an ADHD diagnosis should receive psychosocial interventions; triggers, such as poor parenting or poor schoolteachers, should be addressed; and the social structures that constrain parents and teachers from doing better and having the time and freedom to do so should be addressed.

It is an uphill battle because the indoctrination is so effective. I read in my newspaper in May 2024 in the sports section that a football player "had" ADHD and it explained it was a neuropsychiatric disorder.[519] If you look up neurological disorders on the Internet, you will find scaring diseases such as brain tumours, epilepsy, multiple sclerosis and dementia.

So, I'll say it again, in bold: **ADHD is not a neuropsychiatric disorder**. It is just a name for certain behaviours. The invention of this non-thing is so harmful that it is beyond belief.

5 Psychosis

Chlorpromazine was the first major tranquilliser. When it appeared in 1954, it was considered a chemical lobotomy, as it produced many of the same effects, or a chemical straitjacket, as it kept the patients under control.

Psychiatrists observed it didn't have any specific antipsychotic properties. The patients continued to have delusions and hallucinations but were less disturbing, which was the main reason for the immediate popularity of the psychosis pills. The predominant effects the patients report when they take the pills are sedation, drowsiness, feeling tired, cognitive impairment, emotional flattening or numbness, indifference, loss of motivation, slowed thoughts and suicidality.[520] What they miss the most are themselves.

Defying reason, the president of the US Society of Biological Psychiatry, Harold Himwich, launched the absurd idea in 1955 that antipsychotics work like insulin for diabetes.[521]

These drugs don't even work for psychosis even though they are called antipsychotics. The results obtained in industry sponsored trials are far below the minimally clinically relevant difference to placebo[522] even though it is easy for scores on a ranking scale to improve quite a bit if people are tranquillised and express their abnormal ideas less frequently.

About 20 years ago, a highly prestigious and influential trial funded by the NIMH was carried out, the CATIE trial.[523] I found 191 records on PubMed about it. It randomised 1493 "real-world patients" with schizophrenia to olanzapine, quetiapine, risperidone or ziprasidone, or to a very old drug, perphenazine, marketed in 1957.

The primary outcome was very reasonable, time to discontinuation for any reason, which reflects both the benefits and the harms of the drugs. After 18 months, only 26% of the patients were still on the drug, and perphenazine was not worse than the "atypicals" and did not produce more extrapyramidal harms than the highly praised "modern" psychosis pills,[524] which were hugely more expensive than an old drug off patent.

The authors talked about the comparable levels of effectiveness of the five drugs, but they should have talked about comparable levels of *ineffectiveness*, as all the drugs failed according to the primary outcome.

Cochrane protects the psychiatric guild and the drug industry

Patients may want to be sedated when they have acute psychosis, but a Cochrane review showed that this can be better obtained with a benzodiazepine,[525] which is what all the patients have wanted when I asked them during my lectures. But none of them got it. Patients are routinely treated with neuroleptics, even against their explicit will.

In another Cochrane review, *Benzodiazepines for psychosis-induced aggression or agitation*,[526] the authors wrote in the abstract that, "compared with haloperidol, there was no observed effect for benzodiazepines for sedation by 16 hours." This was a highly misleading denigration of benzodiazepines. Assuming haloperidol works, it seems that benzodiazepines also worked. One cannot say that benzodiazepines have no effect unless the comparator is placebo, and we know that benzodiazepines can calm people down.

I contacted Cochrane about this, but it took four years and a lot of persistence on my part before Cochrane changed it.[527]

At first, in June 2018, I wrote to the primary author, Hadar Zaman, and asked him to correct the abstract. He didn't do that but forwarded my comments to the Cochrane Schizophrenia Group and he said they would come back with guidance.

They didn't. Three months later, I wrote to Zaman again, copying the Managing Editor of the Cochrane Schizophrenia Group, Claire Irving. I said that since I got no reply, I had sent my criticism via the Comments function in the *Cochrane Library*. I also noted that Zaman could easily have made the small corrections to the review I had asked for, without first involving the editor.

Yet again, I was ignored. Irving replied that the group would respond "as soon as possible" but three years later, I had still not heard from the group even though Cochrane is obliged to publish relevant comments alongside the review without delay.

I submitted my comment to the group again, repeating that I wondered why the authors had not quoted a similar Cochrane review that showed that the desired sedation occurred significantly more often on benzodiazepines than on antipsychotics.[528]

Over a year passed, and I still didn't hear from the group's editor. I therefore sent a complaint to Cochrane's Editor-in-Chief, Karla Soares-Weiser. She replied that she would let me know when my comment had been published.

She didn't. Three months later, I checked the review and saw that my comment had been published. But there was no reply to it in the review, and nothing had been changed in the seriously misleading abstract. I considered this editorial misconduct.

In March 2023, I contacted Soares-Weiser again, and in May, John Hilton, Head of Content Publication and Policies, Cochrane Central Executive, wrote to me that the review had been amended (the abstract now said that there was no difference between haloperidol and benzodiazepines), and a response was published.

The only time I ever heard from the Cochrane Schizophrenia Group was four years earlier, when they replied they would respond "as soon as possible." I have experienced several times that, in Cochrane, this can mean many years. The authors never responded either, although this was their obligation. Instead, there was a response from the "Editorial base Cochrane Schizophrenia" within the review, which was problematic. The editors downgraded their error by saying, "sometimes the phrase can be misinterpreted." No, as written, it will *always* be misinterpreted.

The editors did not find it relevant to comment on the Cochrane review that found faster sedation with benzodiazepines than with neuroleptics arguing that it only assessed the acute effect. This was plain nonsense. The review I criticised was about treatments for psychosis-induced aggression or agitation, which are acute conditions.

My comment is now part of the Cochrane review,[529] but, unfortunately, the PubMed abstract is still the misleading one from 2017.

This saga exemplifies that Cochrane mental health groups are so keen to protect the false ideas they have about the drugs that they are willing to sacrifice scientific honesty and the patients to protect the psychiatric guild. Cochrane's logo is "Trusted evidence." I have explained why Cochrane reviews of psychiatric drugs should be distrusted.[530]

The psychiatric textbooks are seriously dishonest

The psychiatric textbooks should also be distrusted.[531] They are seriously dishonest and tell us, for example, that, before antipsychotics arrived, many patients needed to live the rest of their lives in institutions; their discovery was a revolution; many patients clearly improved

their quality of life enabling their reintegration into society; patients who were previously tortured by their disease and were aggressive could now live alone or in protected housing; and the number of hospital beds decreased.

All of this is wrong. There were no references for the extravagant claims, but it has been thoroughly documented that the pills had nothing to do with the emptying of the asylums, which started earlier and was driven by economic considerations.[532] Drugs that do not have clinically relevant effects (see page 73) cannot possibly produce such dramatic outcomes. Moreover, a trial of 127 first-episode schizophrenia patients found that 2–3 times as many patients on chlorpromazine than on placebo were rehospitalised within three years.[533]

Four of the five textbooks claimed that the pills work also for negative symptoms. These include blunted affect, poverty of speech, asociality, lack of motivation, inability to do tasks or activities with an end goal, and diminished capacity to experience pleasant emotions.[534] Two textbooks even claimed that psychosis pills have an effect on cognitive symptoms. This information is mendacious. It has been known for 70 years that the pills *worsen* negative symptoms and cognition.

Bob Whitaker has described how absurd this all is.[535] Imagine that a virus suddenly appears that makes people sleep 12–14 hours a day, move around slowly and become emotionally disengaged. Some gain 30 kg of weight, their blood sugar and cholesterol go up, and some develop diabetes. People infected die substantially earlier than other people, some kill themselves, and parents panic over the thought that their children might also contract this horrible disease. Hundreds of millions of dollars are awarded to scientists to decipher the workings of the virus and they find out that it blocks a multitude of receptors in the brain – dopaminergic, serotoninergic, muscarinic, adrenergic, and histaminergic – which lead to compromised brain function. MRI studies find that the virus shrinks the cerebral cortex, which is tied to cognitive decline. A terrified public clamour for a cure.

Such an illness has hit millions of children and adults. But it is not a virus. What Bob described are the effects of Eli Lilly's bestselling neuroleptic, olanzapine (Zyprexa). Since it is a drug, we accept these harms. Psychiatric drugs are taboo.

Psychiatrists are very poor in spotting serious harms of their drugs. It took psychiatry 20 years to recognise tardive dyskinesia (a terrible movement disorder caused by brain damage, which is often irreversible but masked by ongoing treatment) as an iatrogenic (caused by doctors) illness,[536] even though it is one of the worst harms of psychosis pills and affects about 4–5% of the patients per year.[537] This means that most patients in long-term treatment will develop it. However, in 1987, the president of the American Psychiatric Association said at an Oprah Winfrey show that tardive dyskinesia was not a serious or frequent problem.[538]

In one study, neurologists found 10 patients with tardive dyskinesia while the psychiatrists found only one, and akathisia was diagnosed in 27 vs 7 patients, respectively.[539] There are videos of children and adults with akathisia and tardive dyskinesia that show how horrible these brain damages can be.[540]

Two books claimed that irreversible harms like tardive dyskinesia caused by first-generation drugs can be avoided by using second-generation drugs,[541] but this marketing message is false. The newer drugs are not any better than old ones in clinical effect,[542] which former NIMH director Thomas Insel admitted saying that the notion that they were "breakthrough medications" was wrong.[543]

The textbooks considered clozapine (Leponex) the most effective drug for schizophrenia; some claimed it does not cause extrapyramidal symptoms; and some claimed it reduces mortality or suicides, or both.

None of this is correct.[544] Claims of highly implausible effects should be accompanied by references, but there were none. In one study, 4 of 104 patients treated with clozapine developed tardive dyskinesia.[545] It has never been documented in reliable research that any psychosis pill reduces mortality, but it has been documented in randomised trials that these pills increase mortality substantially (see below). The alleged superiority of clozapine is also highly questionable. There are mediocre meta-analyses that suggest this, but a Cochrane review of good quality did not.[546]

I have advised patients that they should do everything they can to avoid getting treated with a psychosis pill, and also to ensure they can document they warned the doctor, e.g. by recording the conversation, bringing a journalist to the meeting, or demanding a written note from the doctor on the spot, not later. If doctors get in trouble, they often deny what happened, and they might even change the records.[547]

In the package inserts, the FDA warns against using the drugs in pregnancy because neonates may develop extrapyramidal and withdrawal symptoms including agitation, hypertonia, hypotonia, somnolence, tremor, feeding disorder and respiratory distress, sometimes needing intensive care unit support and prolonged hospitalisation.

However, a textbook recommended to treat pregnant women with schizophrenia because untreated psychosis can endanger the life of the mother and child,[548] even though the pills *increase* this risk. The authors noted that FDA's warning *suggested* that the drugs affect the brain in both the child and the mother. This is ridiculous. We have *known* for 70 years that the drugs hamper normal brain functions, which is why they are being used, but according to Danish professors of psychiatry, it is only a *possibility* that psychosis pills can affect the brain. So, if you are caught by the police after having drunk too much, just tell them that it is only a *possibility* that alcohol affects the brain!

The best guarded secret in psychiatry: neuroleptics are highly lethal

It is difficult to find out how many patients doctors kill with neuroleptics. Thousands of trials have been carried out, but when my research group in 2019 searched for placebo-controlled trials in psychosis that only included patients who had not received such a drug earlier, we found only one trial.[549] It was from China and appeared to be fraudulent. As the reported data were impossible to achieve, they seemed to have been fabricated. In 2020, another such trial appeared, and it did not find an effect of psychosis pills in patients with a first-episode psychosis.[550]

Trials in schizophrenia are useless because virtually all patients are already in treatment before they get randomised, and those who are switched to placebo are exposed to cold turkey effects, which increase mortality.[551] Furthermore, about half of the deaths and half of the suicides in trials of psychiatric drugs have been left out in published trial reports.[552]

I therefore focused on elderly, demented patients assuming that few of them were in treatment before they were randomised.

I was shocked. A meta-analysis of placebo-controlled trials in patients with dementia showed that antipsychotics kill one patient for every 100 treated for about ten weeks.[553] The FDA found double as many deaths based on the same trials, two per 100.[554] These drugs are some of the most toxic drugs ever invented and shouldn't be used for anyone.

The psychiatrists are fully aware that the lifespan for patients with schizophrenia is about 15 years shorter than for other people, but they don't blame their drugs or themselves, but the patients and their disease. They very often use high doses or several neuroleptics at the same time, which is serious medical malpractice, as it increases the risk of death without increasing any specific beneficial effects on the psychosis since these don't exist.

Trials have shown that there is no dose-response relationship for neuroleptics.[555] But the clinicians disregard this completely. A typical comment at conferences at psychiatric wards is: "The patient is doing well after two weeks on Zyprexa, so I doubled the dose."

In Denmark, the psychiatrists referred to a report from the Board of Health produced by themselves when they claimed that the use of several antipsychotics simultaneously doesn't increase the risk of death.[556] This cannot possibly be correct, and it turned out that the statistical method used in the report is totally faulty.[557] The report showed that those who got four antipsychotics had a higher mortality than those who got fewer drugs.

The Danish report also showed that half the patients were in treatment with more than one antipsychotic simultaneously, although there are no scientific data in support of this and although both national and international guidelines recommend against it. The record I have heard about was seven antipsychotics simultaneously.

Danish psychiatrists also published a study concluding that, "Risk of natural death did not increase with the number of concurrently used antipsychotic agents compared with antipsychotic monotherapy."[558] It is not a "natural death" to be killed by an antipsychotic. And the mortality was doubled when psychotic patients received three or more antipsychotics simultaneously instead of one. The authors removed this unpalatable result by adjusting for somatic comedication, which is a huge error.[559] The death rate soared, the more drugs for somatic illnesses the patients received (27 times if they received at least 10), and the use of, for example, cardiovascular drugs were 37% and 16% among those who died and those who survived (controls), respectively. The use of diabetes drugs was 12% and 6%, respectively. Since increased doses and the use of several antipsychotics simultaneously increase the incidence of somatic illnesses, it is wrong to adjust for the use of somatic comedication, as this is part of the causal chain from psychosis to death.

Better studies have shown that polypharmacy with antipsychotics increases deaths, as expected. Some of these studies were mentioned in the study's Discussion section.

Countless studies have been concocted to support the lie that psychosis pills *reduce* mortality from psychotic disorders, which two textbooks claimed,[560] but all the studies have serious flaws.[561] Above all, the patients being compared - those on pills and those not - are not comparable. "State of the Art" articles in medical journals are no better.[562]

Bob once wrote to me that it requires extraordinary mental gymnastics by psychiatrists to conclude that these drugs, which cause obesity, metabolic dysfunction, diabetes, tardive dyskinesia, lethal cardiac arrhythmias, and so on, protect against death.

When I tried to find out why young people with schizophrenia die, I faced a roadblock, carefully guarded by the psychiatric guild. It is one of psychiatry's best kept secrets that many patients are killed with psychosis pills. I described my experiences in 2017[563] but subsequent events were even worse.

In 2012, Wenche ten Velden Hegelstad and colleagues published 10-year follow-up data for 281 patients with a first-episode psychosis (the TIPS study).[564] Although their average age was only 29 years, 12% died in less than 10 years, but the authors' detailed article was about recovery and symptom scores. They took no interest in all these deaths, which appeared in a flowchart of patients lost to follow-up and were not commented upon anywhere.

Most patients were still on the pills 10 years after they started, which is frightening, as around half of them would have developed tardive dyskinesia and because many, if not all, would have developed permanent brain damage at this point.[565]

I asked Hegelstad about the causes of death and sent two reminders. She replied they were preparing a manuscript with the information I asked for. But when their paper came out, the number of deaths had changed and the information I needed wasn't there. Two months later, Bob Whitaker and I wrote to the editor of *World Psychiatry*, Professor Mario Maj, asking for his help in getting a unique insight into why so many patients had died so young in Hegelstad's study, which would be "a great service to psychiatry, the patients, and everyone else with an interest in this vitally important issue."

We asked Maj to publish our short letter of 346 words and ensure a reply from the investigators. In particular, we wanted to know why eight patients died from unspecified physical illnesses. Eight days later, Maj replied that, "Unfortunately, although it is an interesting piece, it does not compete successfully for one of the slots we have available in the journal for letters." Six years later, I got the same robotic rejection note when I submitted a letter about another issue to Maj.[566]

How dumb we were to think that mainstream psychiatrists have any interest in helping young people survive by finding out what kills them. I appealed Maj's decision:

"People I have talked to in several countries about deaths in young people with schizophrenia - psychiatrists, forensic experts and patients - have all agreed that we desperately need the kind of information we asked you to ensure we get from the very valuable cohort of patients Melle et al. reported on in your journal. There is widespread and well-substantiated suspicion that the reason we have not seen a detailed account of causes of death in cohorts like the one in the TIPS study … is that the psychiatrists prioritise protecting their guild interests rather than protecting the patients. By declining to publish our letter and get the data out that Melle et al. have in their files, you contribute to that suspicion … Therefore, we call on you to ensure these data get out in the open, for the benefit of the patients. We believe it is your professional and ethical duty - both as a journal editor and as a doctor - to make this happen. This is not a matter about the slots you have available in the journal for letters. It is a matter of prioritization."

We did not hear from Maj again. I have often wondered why it is fruitless to appeal to psychiatrists' inner moral compass. I guess many don't have one and that this is why they became psychiatrists, as they will not be held to account in this specialty.

There are exceptions. Psychiatry professor Merete Nordentoft was forthcoming when I asked her about the causes of death for 33 patients after 10 years of follow-up in the OPUS study of patients with a first-episode psychosis.[567] I mentioned that suicides, accidents, and sudden unexplained deaths could be drug related. Nordentoft sent a list of the deaths and wrote that cardiac deaths were not on the list but that she had seen in the death certificates that some patients had simply dropped dead, one of them while sitting in a chair.

I asked Hegelstad about the conflicting numbers of deaths and for details on the causes of death but didn't hear from her again.

TIPS was supported by grants from 15 funders, which included the Norwegian Research Council, the NIMH, and three drug companies. I asked for detailed information on the deaths, emphasising that funders have an ethical obligation to ensure that information of great importance for public health, collected in a funded study, gets published.

The silence was daunting. Janssen-Cilag replied that they found the data published in *World Psychiatry* fully satisfactory, and they and Eli Lilly encouraged us to contact the

authors, which was absurd, as I had explained that the authors had refused to share their data. Lundbeck did not reply.

In December 2017, the Norwegian Research Council published a new policy that left no doubt that research data should be made accessible for other researchers, without delay. But it took five months after I had written to the Council before I received a letter from Ingrid Melle who had been asked by the Council to respond to me.

I was told I had misread a figure in the original paper where I counted 49 deaths, but the figure was seriously misleading. Melle sent me a table, which wasn't helpful either and her email raised new questions. Why did 16 young people (6%) commit suicide in just 10 years? And why was this vitally important information not explored by the researchers?

We cannot conclude it was their schizophrenia that led to suicide. What was totally missing in the textbooks were the psychological harms psychiatrists inflict on their patients by taking away their hope of becoming healthy again, e.g. by telling them their disease is genetic, or can be seen in a brain scan, or is lifelong, or requires lifelong treatment with psychosis pills, all of which were stated in the textbooks.[568]

Understandably, this increases the risk of suicide considerably. A Danish register study of 2,429 suicides showed a very marked dose-response relationship: The closer the contact with psychiatric staff, the greater the risk of suicide.[569] Patients admitted to hospital would of course be expected to be at greatest risk of suicide because they are more ill than others (confounding by indication), but the findings were robust and most of the potential biases favoured the null hypothesis of there being no relationship. An accompanying editorial noted that it is entirely plausible that the stigma and trauma inherent in psychiatric treatment – particularly if involuntary – might cause suicide.[570]

One textbook mentioned 10 risk factors for suicide, but admission to a psychiatric ward was not among them even though this seems to be the greatest risk of all. It is no wonder patients kill themselves when they are exposed to forced drugging, other forced treatments, involuntary admissions, humiliation, stigmatisation, and loss of hope. Furthermore, when psychiatrists take away the patients' hope of one day living a normal life, why should they then bother about having a healthy lifestyle? If life will never be worth living, why would they then abstain from smoking and drinking?

There were eight deaths from "natural causes" in the TIPS study, but it is not natural for a young person to die.

I wrote again to the Norwegian Research Council again, pointing out that Melle had told me that full information existed on the causes of death. I requested to see this, in an anonymised format. I also noted that Melle had asked me: "Since you are writing with a Nordic Cochrane Centre letterhead, I'm curious if Cochrane has any plans for doing anything in this area?" and said I did not understand the relevance of this question. Why would I *not* use the letterhead for my own centre?

I heard no more. But Melle's inappropriate comment about the letterhead seems to have been part of a concerted effort aiming at removing me from my job as Cochrane centre director.[571]

In my letter to the funders of the TIPS study where I explained they had an ethical obligation to help us get the missing data, I noted that, "We are convinced that patients with psychotic disorders agree with us (I am Protector for the Hearing Voices Network in Denmark)."

One of the funders, the US Stanley Medical Research Institute, did not reply, but psychiatrist Edwin Fuller Torrey, associate director of research at the institute, complained about me

in two letters to the CEO of the Cochrane Collaboration, journalist Mark Wilson. Torrey is a malicious character. Among other things, he wrote:

"The Cochrane Collaboration's credibility rests upon the assumption of objectivity … Such objectivity appears to be very much in doubt for Dr. Peter C. Gøtzsche who identifies himself as the Director of the Nordic Cochrane Center and as the Protector of the Hearing Voices Network in Denmark. This organization promotes the belief that auditory hallucinations are merely one end of a normal behavioral spectrum, thus casting doubt on whether schizophrenia actually exists as a disease, and that hearing voices are caused by trauma in childhood, for which there is no solid evidence. Given such clear lack of objectivity, I personally would not find any Cochrane publication on mental illness to be credible."

Torrey also wrote that the Hearing Voices Network encourages people with schizophrenia to stop taking their medication, and that, "It is very difficult to imagine how anyone with these views could possibly be objective regarding a Cochrane study of antipsychotics, thus impugning your credibility which is your most important asset."

This was bizarre and pure evil. How can my objectivity be "very much in doubt" when I merely inquire about deaths and their causes? Furthermore, contrary to Torrey's assertions, there is solid evidence that psychosis is related to childhood traumas, with a clear dose-response relationship.[572]

Torrey also drew the logically false conclusion that because I am protector of the Hearing Voices Network, no Cochrane publication on mental illness is credible.

The Network sent me an email that I forwarded to the Cochrane leadership when I suggested how they should respond to Torrey. The Network noted they were honoured that I was their protector and that Torrey's comments to Wilson bordered on the ridiculous when he attempted to discredit the whole Cochrane Collaboration. They wanted Torrey to stop using the Network as a platform to insult a respected professor along with the Cochrane Collaboration and suggested he apologised for his disrespectful remarks about voice hearers.

My criticism of the drug industry's organised crime, psychiatric drug trials, and the overuse of psychiatric drugs was never popular with Wilson who changed an idealistic grassroots movement into a business with a focus on brand and sales, and he quickly started bullying me after he had been employed. On this occasion, instead of dismissing Torrey's complaint, he wrote to me that I had broken Cochrane's Spokesperson Policy by using my centre's letterhead and my title and that this would reasonably lead any reader to assume that the request was from the Nordic Cochrane Centre and that the views expressed were those of the centre.

Wilson wanted to apologise to Torrey for "any confusion in this regard." Quite interesting, that one bully wants to apologise to the other bully when the person between the bullies has done nothing wrong.

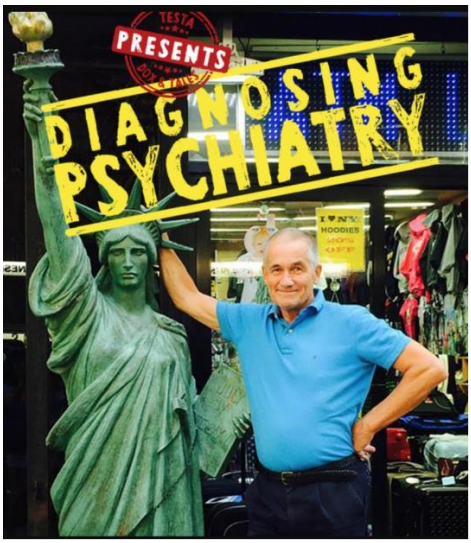
The setup was ridiculous. Cochrane's own lawyer didn't find I had broken the Spokesperson Policy,[573] but such trifles don't matter for bullies. Wilson invented a fake problem. It was clear the request came from the centre and that I as Director was authorised to speak on behalf of my centre. My views were even shared by my staff. Furthermore, my letter was not a public announcement, but a letter to a funder. No one could become "confused."

US lawyer Ryan Horath described the farce this way:[574] "Cochrane leaders became obsessed about Gøtzsche using Nordic Cochrane letterhead to send this request. And a very large number of people seem to agree with the board's obsession ... JESUS CHRIST, WHAT IS WRONG WITH YOU PEOPLE? A researcher is making inquiries about the suppression of information regarding children who died in a clinical trial and everyone is worried about

what letterhead it is written on? … Even worse, it is clear the outrage over use of Cochrane letterhead is feigned outrage, as this was a private letter. Was Fuller Torrey confused about whether the letter represented Cochrane's views? Apparently not … Instead, Torrey argued that Gøtzsche was not 'objective' and this damaged Cochrane's reputation - something totally different ... So, Cochrane leadership's use of this complaint in its case was misleading. The complaint is about one thing, and they used it as evidence of another (false allegation). That is how kangaroo courts operate."

Diagnosing psychiatry

Danish filmmaker Anahi Testa Pedersen made a film in 2017, *Diagnosing Psychiatry*, about what I want to accomplish:[575]



I suggested this title because the film shows that psychiatry is like an illness that can infect healthy people, which also happened for Anahi. She got the diagnosis schizotypy in 2009 when she became severely distressed over a difficult divorce. She jokes about the diagnosis in the film, and it is obvious that she should never have had a psychiatric diagnosis or been treated with drugs.

However, at Bispebjerg Hospital they gave her quetiapine (Seroquel), a psychosis pill, and escitalopram (Lexapro), a depression pill. Anahi was deeply shocked to learn that although she had voluntarily contacted the psychiatric ward, the doors were locked behind her.

When she questioned her diagnosis at discharge, she was told: "Here, we make diagnoses!"[576] The drugs doped her and made her indifferent, and she withdrew from them.

Another shock came eight years later when she received a letter from Psychiatry in the Capital Region. They wanted to examine her daughter believing that psychiatric disorders are inherited. Understandably, Anahi became angry. The letter stigmatised both her and her daughter who was well functioning, happy, healthy and had many friends. The summons came without her being asked about her course after discharge, or her daughter's situation and well-being.

Anahi phoned a psychiatrist at the department where she had stayed, but even though her family doctor had assured her that she was well and doubted her diagnosis was correct, she was told, when she asked for a re-examination: "The system doesn't do that!"

She was left with a lifetime, yet erroneous, sentence. This wouldn't have happened if she had been wrongly sentenced for a crime, but in psychiatry, this is perfectly "normal."

After many years of trying, she finally became de-diagnosed, in 2024, as the new diagnostic guidelines (ICD-11) allow this.

I had no idea what Anahi's monster was supposed to be, so I looked it up on the Internet and found a test for schizotypal personality disorder. The test was farcical and, as I have explained,[577] many, perhaps most, psychiatrists would test positive! Moreover, the test may lead to circular evidence. Healthy people might test positive when they have been treated inhumanely by psychiatrists, including being forcefully treated with psychosis pills.

This diagnosis, and most other psychiatric diagnoses, should be discarded. We should focus on the patients' problems, and not on a diagnostic system that is arbitrary, unreliable, and unscientific.[578]

Psychosocial interventions are much better than drugs

Ironically, patients with psychosis fare much better if they are not treated with so-called antipsychotics.[579] Psychiatrist Loren Mosher wasn't against using the drugs, but he opened a 12-room Soteria house in 1971, as he wanted to treat acutely psychotic people in a humanistic way with empathy and caring. There were no locks on the doors, and the patients were treated with respect. His staff were not mental health professionals but people who had social skills and empathy and listened to the patients' stories, which often revealed traumas with abuse and extreme social failure.[580]

Mosher paved the way for the Open Dialogue approach in Lappland. A comparison with Stockholm shows the difference between an empathic approach and immediately forcing drugs on patients with a first-episode psychosis.[581] The patients were closely comparable, but in Stockholm, 93% were treated with psychosis pills against only 33% in Lappland, and five years later, ongoing use was 75% versus 17%. After five years, 62% versus 19% were on disability allowance or sick leave, and the use of hospital beds had also been much higher in Stockholm, 110 versus 31 days, on average. It was not a randomised study, but the results are so striking that it would be irresponsible to dismiss them, and many other studies support a non-drug approach to acute psychosis.[582]

The good results obtained by Mosher, also in a randomised trial, were very threatening to other psychiatrists.[583] His patients had fewer relapses and functioned better in society in terms of holding a job and attending school than those on drugs. It was also offensive to other psychiatrists to suggest that ordinary people could help crazy people more than psychiatrists with their drugs.

Mosher was the chief of the Center for Studies of Schizophrenia at the NIMH, so it wasn't obvious how he could be stopped. The NIMH clinical project committee raised doubts about the rigour of his research and reduced the funding so much that it was a kiss of death. Mosher tried to get funding from another NIMH division and the review committee was very enthusiastic. However, the clinical projects committee killed his project with derogatory remarks about the study's postulated "serious flaws" and said that further funding would only come forward if Mosher stepped down so that the committee could redesign the project with another investigator.

This is one of the ugliest manoeuvres I have ever seen being used against a highly respected investigator who was a treasure for the patients. Later, Mosher was kicked out of the NIMH, and he bitterly said: "If we were getting outcomes this good, then I must not be an honest scientist." Others in America who questioned the merits of psychosis pills learned quickly that this would not advance their career, and NIMH did not allot any more funds to such heretic projects.[584]

The organised denial is overwhelming, and it is still with us. In 2016, Jan Ivar Røssberg, professor and head of teaching in psychiatry at the University of Oslo, claimed in a newspaper that drug-free treatment of psychosis lacks any support in science.[585] In 2017, he and his colleagues claimed in the *Norwegian Medical Journal* that neuroleptics work for most people; reduce mortality; and increase their functional capacity and quality of life. I implied in both media that Røssberg lied without saying this directly.[586] In his reply, Røssberg mentioned that I continued with my anti-psychiatric crusade.[587]

The chair of the Norwegian Psychiatric Association, Ulrik Fredrik Malt, claimed in a newspaper that my statements that antipsychotics kill many patients and prevent them from returning to normal life were false.[588] He opined the drugs can help some to return to a relative normal life.

However, under the heading, *Professors spread fear, half-truths and lies*, a patient organisation supported me and criticised Røssberg and Malt for having very little respect for the users.[589] They noted it was a lie that most patients took antipsychotics voluntarily because many were threatened that if they didn't, force would be applied.

A systematic review showed that cognitive behavioural therapy for schizophrenia improves clinical outcomes at no additional cost, and economic modelling suggested that it might even result in cost savings because of fewer hospital admissions.[590]

Psychiatrists tend to ignore such information, but they found out recently that if they talk more with their patients, there is less need for forced treatment. Merete Nordentoft conveyed this experience in a TV debate with me. I wondered why this was something psychiatrists should discover. Shouldn't they have known this all along?

Fortunately, there were many remarks in the textbooks about the positive effects of family involvement, outreach, assertive community treatment on patient terms, multidisciplinary teams, cognitive behavioural therapy, and neurocognitive training.[591] The OPUS study in Denmark and the AESOP study in England showed that over half of the patients no longer had psychotic symptoms after 10 years, and studies showed a reduction in readmissions, fewer hospital days, a halving of the risk of relapse, and an effect on psychotic symptoms, drug abuse, and even negative symptoms.

One book noted that supported employment made it three times more likely that the patients would find work, with reference to a Cochrane review.[592] The review noted that the evidence was of very low quality, mainly because none of the 14 studies were blinded. It is unfortunate when Cochrane researchers slavishly follow the Cochrane cookbook approach and downgrade the results of psychosocial interventions because they cannot be blinded, as they are so clearly superior to drugs. Moreover, the objective effects of family intervention, psychoeducation and mindfulness in terms of employment and hospital admissions,[593] cannot be explained by bias caused by lack of blinding.[594]

Another issue with Cochrane cooking is that Cochrane reviews are far too wordy. A review of shared decision making included only two studies, but the authors wrote 45 pages about them even if they could not conclude anything.[595]

We need not study shared decision making in randomised trials. It is an ethical imperative that we respect the patients and involve them in our decisions. This principle cannot be suspended because the patients are psychotic, according to the United Nations Convention on the Rights of Persons with Disabilities,[596] which has been ratified by virtually all countries except the United States.

Lithium and antiepileptics

The hospital-based psychiatry in one of the Danish regions mentions on its homepage that "Drugs for bipolar disorder - mood stabilising drugs - can prevent and cure depression, mania and mixed conditions in most people."[597] This is false. Psychiatric drugs have symptomatic effects. They cannot prevent or cure anything.

Lithium is a highly toxic metal used for bipolar psychosis. It sedates people and renders them inactive, but psychiatrists praise the drug highly, saying it works and prevents suicide.

A Swedish psychiatrist in training, Joakim Börjesson, stayed with me for three months in 2017 to research this issue. Joakim is much brighter than the average psychiatrist, and he considered leaving psychiatry after he realised, from reading books by Bob Whitaker and me, that he had been totally fooled during his medical studies. He had been told that psychiatric drugs were specifically targeted to work on a disorder's biological origin, which he found so fascinating that he decided to become a psychiatrist.

We excluded the cold turkey trials and were left with only four trials. There were three suicides on placebo and none on lithium, and nine versus two deaths, but as half of all deaths are missing in psychiatric drug trials, we did not draw any firm conclusions.[598] We do not know if lithium helps because the trials had highly subjective outcomes and must have been poorly blinded because of the pronounced adverse effects of lithium. This is not a drug I would recommend to anyone.

By and large, the information on lithium in the textbooks was incorrect. One book, edited by Poul Videbech, claimed that lithium has a prophylactic effect in schizoaffective disorders and can dampen aggression,[599] with no reference. However, a 2015 systematic review of 22 trials of lithium for schizophrenia found no reliable evidence that lithium works.[600] I updated the search in April 2022 by searching on *lithium schizo** in the title field on PubMed and did not find any additional trials.

One book claimed that lithium prevents suicidal behaviour in children,[601] but there is no evidence that this is correct. Three books claimed that lithium is neuroprotective, and two of them that the drug prevents dementia, with no documentation for this wishful thinking.

Antiepileptic drugs are also used for bipolar psychosis, and a lot else. The psychiatrists have justified this by calling them "mood stabilisers," but never really defined what it means. Their main effect is to suppress emotional responsiveness by numbing and sedating people, or by stimulating them, and they double the risk of suicide.[602]

How did drugs with such effects ever come to be described with the positive term "mood stabiliser?" They don't stabilise anything. They destroy people, e.g. one in 14 patients on gabapentin (Neurontin) develops ataxia (see the package insert), which is a lack of voluntary coordination of muscle movements. And the clinical trials are characterised by massive fraud.[603] I have often encountered patients who were on lamotrigine. Only two positive trials were published for this drug, while seven large, negative trials were not.[604] But the FDA regarded the others as failed trials and approved the failed drug.

Another commonly used drug is pregabalin, which has the seductive trade name Lyrica. There is nothing lyrical about becoming sedated or euphoric, and having your suicide risk doubled.

The textbook Videbech edited claimed that some antiepileptics can be used for prophylaxis of bipolar.[605] There were no references, but systematic reviews do not provide support to this claim. Two books claimed that electroshocks are effective in 60–80% of the patients, which are meaningless statements, as there is no control group.

I would not recommend these drugs for psychiatric patients.

6 Dementia

Let's start with a little common sense. How likely is it that a drug will slow down degenerative processes in the brain? Very close to zero. How likely is it that the drug trials are biased? About 100%. How likely is it then that the trivial effects measured on some rating scale in drug trials that are not effectively blinded are real and important? About zero.

At a meeting at my hospital, a clinical pharmacologist acknowledged that the drug effect is so small that it is irrelevant. However, he said the drugs could be tried anyhow because some patients respond better than others. With this argument, we could use anything that doesn't work, even homoeopathy. I told him a little about statistical variation. If the trial is repeated in the same patients, other patients will falsely seem to respond.

Imagine your old car is causing problems and your mechanic tells you that his fix doesn't work, but that he hopes it would work for your car. Why is it so difficult for doctors to realise that the way they use drugs, they would never want their mechanic to copy?

Doctors ignore or don't know that their clinical experience is greatly misleading. They start patients on ineffective drugs and see how it goes. In contrast to cars, many patients become better with time, and then they draw the false conclusion that the drug worked.

Drug authorities are just as unreasonable. Numerous package inserts recommend trying a drug and see how it goes.

So, what about textbooks? Alas, they are all highly misleading.[606] *All* the claims about positive drugs effects were wrong, and there wasn't a single reference to placebo-controlled trials or meta-analyses. The books spoke of miraculous effects: acetylcholinesterase inhibitors can improve cognitive functions, apathy, hallucinations, delusions, other neuropsychiatric and psychological symptoms; can inhibit the progression of the disease for months to a few years; can reduce the decline in functional level and behaviour; and can lead to a resumption of earlier activities.

In 2022, journalists wrote in a newspaper that drugs "can slow down the development of dementia for up to a few years in many people." I was allowed to rebut this.[607] They were obviously lied to by the professionals they interviewed.

A 2006 Cochrane review of donepezil, galantamine and rivastigmine, didn't pay any attention to the bias problem and concluded that the cholinesterase inhibitors are efficacious.[608] However, the improvement in cognitive function was 2.7 points, in the midrange of a 70-point scale, and less than the 4 points the FDA considers the minimally clinically relevant change.[609] The author wrote that "donepezil appears to have no serious or common side effects," which is so egregiously false that Pfizer would hardly have dared claim it in their ads for the drug.

The harms are both common and serious, which the author demonstrated herself, as 29% of the patients dropped out when on drug, compared to only 18% on placebo. The most common harms listed in the package insert are nausea, diarrhoea, insomnia, vomiting, muscle cramps, fatigue, and anorexia,[610] not exactly what we would want for an old person who might already have some of these problems.

The list of frequent harms is very long. Hypotension and syncope occurs in over 1% and when old people fall and break their hip, about 20% will die within a year. A Canadian study showed that people who took dementia drugs almost doubled their risk of hospital admission, and they broke their hips and had pacemakers inserted more often.[611] Amazingly, more than half the patients who were admitted to hospital with a pulse that was too low were

treated with the same type of drug after discharge. Yet another proof that doctors cannot handle psychotropic drugs safely.

A 2014 study of 5,406 nursing home residents in the USA with advanced dementia found that one third received cholinesterase inhibitors and one fourth memantine, another dementia drug.[612]

No benefits for society have been found,[613] which is interesting as we so often hear about the economic burden of dementia and how important it is to intervene with drugs, particularly from politicians when general elections come close.

A long-term trial of 565 patients with Alzheimer's disease that compared donepezil with placebo found no meaningful effects, and the authors concluded that the drug isn't cost-effective, with benefits below minimally relevant thresholds.[614]

In contrast to the other trials, this trial was publicly funded. It was excluded from the Cochrane review with the invalid excuses that two dose groups were not reported separately and that "Complex design and high numbers of dropouts made analysis and interpretation difficult." As it was a long-term trial, a high drop-out rate was expected. The outcome after three years was similar on drug and placebo for institutionalisation, progression of disability, and behavioural and psychological symptoms.

Extremely few trials in psychiatry run for years but such trials are exactly those we need instead of the thousands of pretty useless short-term trials we have.

Six years after the trial was published, Pfizer's TV commercials for Aricept implied that the patients' cognitive and daily functioning, attention, focus, orientation, communication, social interaction and engagement will be restored to normal; "Don't wait, talk to your doctor about Aricept."[615] I would say, "Don't wait, talk to your lawyer about Pfizer." The FDA told the company that - with its huge lies - it had broken the law.

You should not talk to your doctor because, as the textbooks so clearly showed, your doctor is highly likely to mislead and harm you.

Three critical comments were published with the 2006 Cochrane review, including mine. Unfortunately, contrary to good scientific practice, they are undated. The author apologised for an error, which she said would be corrected in the next version, and she replied to me that another error had "also now been corrected." It was not corrected. In 2015, I was told that "An update of the review … is in preparation." The review has not been updated. It stands as a gravestone over Cochrane, once a magnificent organisation, today in free fall.[616]

Other Cochrane reviews of dementia drugs are not encouraging either, e.g. one in vascular dementia concluded that donepezil and galantamine have a small effect on cognition that is unlikely to be clinically important.[617]

Demented people are often treated with psychosis pills, not because they are helpful but because they make the patients less disturbing. However, two doctors who work with these patients claimed in a textbook that neuroleptics have a documented effect in dementia. This demonstrated once again a general issue: Clinicians are carried away by their "clinical experience." A chapter about psychopharmacology in the same book advised against neuroleptics due to the lack of evidence for an effect on dementia, increased sensitivity to harms, and an increased risk of stroke.

As it cannot possibly be true that psychosis drugs work for dementia, I searched for trials that claimed to have found this, but I didn't find any. I found a trial of olanzapine,[618] but it was about calming down disturbing Alzheimer patients with a major tranquilliser. The patients became somnolent and developed gait disturbances.

It is futile to search for drugs that work for dementia. It is the other way around. Likely all psychotropic drugs can cause brain damage, and a hallmark of this is impaired cognitive function.[619] The Framingham Heart Study found that use of depression pills increased the risk of developing dementia by about 50%,[620] and benzodiazepines seem to double the risk of dementia.[621]

We should avoid drugging demented people and care for them instead. A systematic review of trials of agitated demented people showed large effects of care, e.g. communication skills training, activities, music, touch, massage and talking to people.[622]

Maybe we have too many doctors in the western world. I have not met a single geriatrician who didn't use dementia drugs. Prescribing drugs provides doctors with prestige, authority, and a meaning, and once started, it gives them something to talk about with the patients or their relatives. Like children, doctors cannot keep their fingers away from dangerous toys, which is why we should take all the ineffective and dangerous psychiatric drugs off the market.

So-called "State of the Art" articles in medical journals are - despite their pompous name - some of the most misleading articles we have, and dementia is no exception. In such an article, Peter Høgh, from a Regional Knowledge Centre for Dementia, wrote that it has been shown in several Cochrane reviews that acetylcholinesterase inhibitors are effective in Alzheimer's. He also claimed that the drugs have an effect on cognition, activities of daily living, and neuropsychiatric symptoms, and that the loss of function is postponed for a minimum of 6–12 months. I explained in our medical journal that none of this is correct.[623]

There is no good reason to use drugs against dementia but many good reasons not to use them.[624]

7 Electroshock

Electroshock, also called electroconvulsive therapy (ECT), "works" by damaging the brain.[625] Psychiatrists observed right from the beginning that patients lost their memories, which are what defines us as humans, and made people confused. It took weeks for them to recover, and they often remained fatigued, intellectually impaired and disoriented, and acted in submissive, helpless ways.

The "effect" rather quickly dissipated, and the illness returned. The shocks should therefore have been abandoned, but instead, a perverse idea was invented: repeating the shocks numerous times.

Psychiatrists' skills in turning the facts upside down to sustain their harmful practices are second to none. They describe these effects as positive. It is worth remembering that they also described lobotomy and the many other barbaric treatments they used in the past in positive terms.

Some psychiatrists did not delude themselves. They reported that electroshock produced similar changes in the brain as physical trauma, with haemorrhages, both in animals and people, particularly in the cortex, which in some cases led to permanent impairment of learning capacity, perception of reality, inventiveness, intuition and imagination.[626]

The descriptions of ECT in the textbooks I read were seriously dishonest. Three books noted that ECT stimulates the formation of new neurons in the brain and presented this as something positive. They forgot to say that the brain reacts to brain damage by producing new neurons, even though it had been shown already in the 1940s that ECT causes brain damage with necrosis in the brain in autopsy studies.[627]

Unfortunately, it is common in psychiatry to praise a harmful effect as if it were beneficial. There were no references in the textbooks and two of them were mendacious, as they claimed it has not been possible to detect brain damage.

Electroshock was highly praised in the textbooks, particularly for treatment resistant depression, and the denial of its harms was astounding.[628] Several authors ignored what the patients told them and claimed that it was difficult to know if the memory loss was caused by ECT or their disease, which is the standard script for psychiatrists: Blame the victim, not the treatments. In addition, the memory loss was trivialised. For example, one textbook noted that some studies suggest a slight memory loss a year after ECT whereas other studies do not. Another textbook claimed that prolonged experiences of "inconveniences" are extremely rare, and other books downgraded this even more by calling the inconveniences "subjective" as if they didn't exist at all.

The truth is that memory problems have been verified in numerous studies and that they are serious. ECT causes memory loss in most patients, permanent memory loss in some, and kills some of the patients.[629] Reports by patients of memory loss are about retrograde amnesia (forgetting things that happened in the past), and they are damning. With a strict definition of memory loss, between 29% and 55% of the patients are affected. With looser criteria, the range goes from 51% to 79%.[630]

Many psychiatrists believe ECT can be lifesaving, but there are no reliable data in support of this,[631] whereas we know for sure that ECT can be deadly. A systematic review found a death rate of about 1 per 1000,[632] which is 10 times higher than what the American Psychiatric Association says. In April 2024, I interviewed the first author of this review, psychology professor John Read, for our Broken Medical Science podcast. John told me that, as a young

man, he witnessed a patient being killed by ECT on the table and that the death was covered up subsequently. This spurred his interest in ECT.

When I lectured in Brisbane in 2015, a woman told me that the psychiatrists killed her son with ECT, but they resuscitated him. When he woke up, he had severe burns and the next two to three months he couldn't say anything people could understand. He is permanently brain damaged and his social skills are very poor; he cannot live on his own.

One textbook noted that ECT is extremely effective against severe depression, which agrees poorly with the information in the same book that, usually, 8–16 shocks are given. The book also claimed that ECT can be lifesaving and that 80% of patients with affective disorders respond to ECT, which is a meaningless statement, as there was no control group (and no reference either).

Systematic reviews have failed to find benefits beyond the treatment period, both for depression and schizophrenia.[633] As all sham ECT trials are grossly flawed,[634] it was not impressive that a 2003 review found that ECT was more effective than sham ECT for depression, effect size 0.91, corresponding to a Hamilton score difference of 10.[635] This was a short-term effect; the quality of the trials was poor; most trials were small; the trials rarely used outcomes relevant for clinical practice; and the data suggested that ECT caused cortical atrophy in the brain. The authors advised that the trade-off between making ECT optimally effective in terms of amelioration of depressive symptoms and limiting the cognitive impairment should be considered. They should have said that it is uncertain if ECT for depression does more good than harm. There is no Cochrane review of ECT for depression, but a protocol was published in January 2022 by some of my former employees.[636]

For schizophrenia, a 2005 Cochrane review reported that more people improved on ECT than on placebo or sham ECT, risk ratio 0.76. However, this result is not reliable.[637] It was barely statistically significant; the trials were small and the larger the trial, the smaller the effect; and the authors accepted trials where up to 50% of the patients were lost to follow-up. Using the Brief Psychiatric Rating Scale, ECT was better than sham ECT, but there were only 52 patients in the analysis, and the difference was only 6 on a scale that goes to 126. This cannot be a clinically relevant effect, and ECT was considerably *less* effective than psychosis pills, which we know don't work.

In 2003, the UK Royal College of Psychiatrists' fact sheet stated that more than 80% of depressed patients respond well to ECT.[638] It is nauseating that so often psychiatrists use data without a control group, which is how quacks argue. The fact sheet also claimed that the memory loss is not clinically important, but the patients disagreed, and the lowest satisfaction levels were obtained in studies led by patients rather than by psychiatrists.

Let's use a little irony here: The memory loss for the psychiatrists is substantial and clinically important for their patients. If we want to know the truth about ECT and psychiatric drugs, we should listen to the patients and not to the psychiatrists. A Danish patient couldn't even remember the name of the Danish capital, after she was electroshocked.[639] She was permanently brain damaged by ECT but was told it was her "disease" and not the shocks. Moreover, she should never have received ECT. Her problem was that she had been sexually abused as a child. She didn't have any psychiatric disorder.

It is dishonest to say, as the psychiatrists who authored a Cochrane review of depressed elderly did,[640] that, "Currently there is no evidence to suggest that ECT causes any kind of brain damage, although temporary cognitive impairment is frequently reported" and that

"ECT seems to be a safe procedure." Allow me to ask: If the cognitive impairment was not caused by ECT induced brain damage, what caused it?

The 2010 official guidance for general practitioners in Denmark on depression stated that, "Many have an unfounded fear of ECT treatment, although there is no evidence that the treatment causes brain damage; in fact, there is strong evidence that new nerve cells are formed in response to treatment."[641]

ECT in clinical practice is far worse than the results in carefully conducted randomised trials suggest. Repeated audits by the Royal College of Psychiatrists showed that many hospital trusts failed to adhere to the college's standards; one audit found that only a third of ECT clinics met the standards; and there are huge variations in clinical practice and in rates of usage.[642] In Denmark, forced treatment with ECT has quadrupled in just seven years in the 1990s. This is despite the fact that it is immensely unpleasant; it is frightening to patients; it often elicits colossal bitterness and anger; and it is perceived by patients as a serious breach of trust.[643]

I have heard many stories about miraculous effect and grateful patients. I was once asked at a meeting what my view was about a woman who was so depressed that she could hardly be contacted but asked for a glass of water after an electroshock. I said that since this was an anecdote, I would reply with another anecdote. I examined a newly admitted man, an unconscious alcoholic, and as I needed to rule out meningitis, I tried to insert a needle in his back to tap cerebrospinal fluid for microscopy and culture. It was very difficult to get in and I hit his bone several times. All of a sudden, the drunkard exclaimed loudly: "Bloody hell, stop stinging me in the back!" Had I caused a miracle with my needle and cured the guy? No. Odd things happen all the time in healthcare. Could I have woken up the deeply depressed woman with my needle? Who knows?

There is a very moving documentary about Mette Askov, a Danish nurse who had heard voices since she was 8 years old and lost 15 years of her life to psychiatry.[644] She was diagnosed with paranoid schizophrenia and received vast amounts of medicine, 150 electroshocks and a disability living allowance. She was stigmatised and surrounded by prejudice but after she left psychiatry and reclaimed her life, she achieved some of her greatest goals. Her story illustrates so well what the psychiatrists' abuse of forced treatments can lead to. Even when they clearly don't work, psychiatrists continue using them.

Some psychiatrists I have met have never used electroshock and some countries don't use it at all, e.g. Slovenia. This barbaric treatment should be made illegal, just as lobotomies were. At the very least, no one should be forced to get ECT against their will.

8 Psychosocial interventions

Psychosocial interventions, which include psychotherapy, should be the treatment of choice in helping patients suffering from mental health issues. Just taking an interest in the patients and their family, can be more important than anything else. The process can change the way people view themselves, their surroundings, their past and their future, and how they interact with other people.

Psychiatric drugs change the brain. They create an artificial third state - an unknown territory - that is neither normal nor the malfunctioning state the patient came from.[645] This is problematic because you cannot go from the chemically induced third state back to normal unless you taper off the drugs, and even then, it will not always be possible, as the drugs might have caused irreversible brain damage.

I would not advocate combination therapy. Doing effective psychotherapy can be difficult when the patients' brains are influenced by psychoactive substances, which may render them unable to think clearly or to evaluate themselves. The lack of insight into feelings, thoughts and behaviours is called medication spellbinding.[646] It causes the patients to underestimate the harms of the drugs and to overestimate their benefits.

Studies with long-term follow-up show that psychotherapy has an enduring effect that outperforms drug therapy.[647] And a huge network meta-analysis (81 trials and 13,722 patients),[648] found that pills do not add anything to the effect of psychotherapy in patients with depression.

But the authors drew highly misleading conclusions.[649] They tried to defend the prevailing belief among psychiatrists that depression pills are good for people. They even implied, despite their negative findings, that a combination of pills and psychotherapy has merit and failed to inform their readers that pill treatment can be fatal. As noted in the chapter on depression, depression pills double the risk of suicide[650] whereas psychotherapy halves this risk.[651]

Treatment outcomes depend more on the quality of the therapeutic alliance between the physician and the patient than on whether the treatment being used is psychotherapy or pharmacotherapy.[652] The more in agreement the physician and the patient are about what is important, the better the outcomes for positive affect, reduced anxiety and social relationships.[653]

I have met psychiatrists in several countries that don't use psychiatric drugs or electroshock. Many of them treat even severely disturbed patients with empathy, psychotherapy, and patience.[654]

Physical and emotional pain are similar. We need physical pain to avoid danger, and we need emotional pain to guide us in life. Åsa Nilsonne, Swedish professor of psychiatry at Karolinska Institutet, doesn't use drugs. She argues that non-drug treatment allows patients to learn something important through the process of healing that can boost their self-confidence and be useful if they get in trouble again.[655] She has also noted that doctors may think they need not engage themselves as much when a patient is taking drugs, as they believe the drug will do the work for them. When my first book about psychiatry had been translated into Swedish, my publisher arranged two public meetings in Stockholm in 2016 where Åsa was chair. They were very well attended. There were a few very aggressive psychiatrists in the audience who lost the debate. They failed to challenge the arguments presented in my book and they presented the usual arguments in favour of using psychiatric drugs - including that they protect against suicide - that I had debunked in the book.

The first meeting was announced with these statements: The way we use psychiatric drugs does much more harm than good; in the USA and Europe, psychiatric drugs are the third leading cause of death; their use should be reduced by 98%;[656] biological psychiatry, which prescribes drugs against almost any mental health issue, is a disastrous failure.

Most problems patients face are caused by maladaptive emotion regulation, and psychiatric drugs make matters worse, as their effects constitute maladaptive emotion regulation. In contrast, psychotherapy aims at teaching patients to handle their feelings, thoughts and behaviour in better ways, which is adaptive emotion regulation. It may permanently change patients for the better and make them stronger when facing life's challenges.

I shall not go into detail about psychotherapy. There are many schools and methods, and what is most important is that the therapist is a good listener and meets the patient where that person is, as Danish philosopher Søren Kierkegaard advised us to do two centuries ago.

Psychotherapy is the best intervention we have, and I have explained elsewhere[657] that it is useful for most psychiatric disorders, also psychoses. It doesn't work for everyone, but like in other areas of healthcare, we need to accept that some people cannot be helped no matter what we do. For example, it doesn't always work out if the patients try another therapist.

In the late 1970s, psychiatry in the USA was worried about its survival; the public viewed its therapies as having low efficacy; and sales of psychiatric drugs were in decline.[658] Unfortunately, the psychiatrists have won the battle with the psychologists. Psychiatry rebranded itself with the diagnosis manual DSM-III in 1980 and invented a lot of dubious mental disorders with arbitrary criteria along the line:

Find five faults with a patient out of nine and you have a diagnosis. Psychiatrists began giving the public the impression that these constructs were real diseases, just like diabetes and cancer, and that the drugs they prescribed for these alleged diseases corrected a chemical imbalance, in the same way that insulin does in diabetes.

The psychiatric textbooks showed that psychiatrists have absolute power over everything in mental health, and that psychologists and other professionals were left to the sidelines. There wasn't much mention of an independent role of psychologists. Psychotherapy was often listed as an option, but almost always in a context that also involved drugs, and it was implicitly understood that psychotherapy was the responsibility of psychiatrists.

When psychologists were mentioned, their role was limited to administering psychological tests, including projective personality tests such as the Rorschach test, which involves showing the patients a series of inkblots and asking them to explain what they see in those figures.

Oddly, this display of power was particularly clear in the textbook about child and adolescent psychiatry,[659] even though psychotherapy and other psychosocial interventions have a stronger standing in children than in adults.

What would be important in the treatment of children, is to assist and to support them learning essential social and emotional skills that improve their ability to adjust to their surroundings (see Kids'Skills, in Chapter 4 on ADHD).

But all the editors of this textbook were psychiatrists, and they protected their guild carefully. There was nothing about how psychologists could help children, and the advice contained a pleonasm: If a person has a mental disorder, there is psychopathology suggesting a psychiatrist is needed, but it is just another name for the same thing.

It was disappointing that most psychologists agreed with the view of psychiatrists, and that they were sometimes even more radical and uncritical than them, e.g. in their praise of what brain imaging studies can tell us about psychiatric disorders and of drugs. Perhaps the reason is that, in a radicalised group, newcomers tend to be even more radical than their leaders to become accepted as their equals. Fringe groups therefore tend to become more radical with time. Furthermore, often supported by their scientific associations, some psychologists want to get permission to prescribe drugs. They will not succeed if they are seen as critics of mainstream psychiatry.

The textbook, *Clinical neuropsychology*, which has three psychologists as editors, illustrates this.[660] Three pages describe imaging studies in depression, with many references, which conveys the false message to the students that we know a lot about the brain, based on reliable studies. The truth is that we know next to nothing.[661]

The textbooks recommended psychotherapy for mild or moderate depression whereas severe depression was to be treated with pills and electroshock.[662] This is a familiar, yet absurd, theme. The worse the disease, the more the patients shall be harmed by harmful treatments. One book focused totally on pills, for all severities of depression, and psychotherapy was only a means aimed at keeping the patients on pills!

The disrespect for patients was enormous. When laypeople were asked what sort of treatment they would prefer, six times as many people preferred psychotherapy for pills,[663] but a 2002 survey of US child and adolescent psychiatrists showed that only 9% of the patients receive psychotherapy without pills.[664] A US psychiatrist said: "When I trained back in the 80s, we got 50 percent psychotherapy training and 50 percent biologic medication training. Today, the average psychiatric resident gets zero psychotherapy training. So, all they have to offer is a pill."[665] In Sweden, the Board of Health recommends that all adults with mild to moderately severe depression are offered psychotherapy, but only 1% get it.[666]

A textbook claimed that the preventative effect of drugs is better than psychotherapy, but this is false and was contradicted by another book noting that the effect of psychotherapy lasts longer than that for drugs.

Nonetheless, one book claimed that the effect of the combining a drug with psychotherapy was larger than those of drug or psychotherapy alone in chronic depression. This statement is meaningless. What is chronic depression and why would a combination work for chronic depression when it does not work for depression?

Two books stated that psychoeducation may halve the risk of new depressions or manias in bipolar patients and reduce hospital admissions but added that this was probably because of better treatment compliance with drugs. The reference to this claim was a randomised trial of psychoeducation,[667] which showed the claim was false: "Compared with control patients, psychoeducated patients had higher lithium levels at the 2-year follow-up, which may suggest an effect of psychoeducation on pharmacotherapy adherence." This speculation was ridiculous, and the lithium levels were about the same, 0.76 vs 0.68 mEq/L.

A chapter on psychotherapy written by professor of psychology Nicole Rosenberg was unusually well documented. She wrote that cognitive behavioural therapy has a small effect in schizophrenia; is effective against depression, also in preventing relapse and in getting people back to work; and works for anxiety, with large effects for generalised anxiety, social phobia, and post-traumatic stress disorder (PTSD).[668]

That psychotherapy can get depressed people to return to work is a very important piece of information. Depression pills have the opposite effect. The rate of disability pensions follows the usage rates for depression pills.[669]

Psychiatry is a perverse trade. It doesn't help the patients as they want to be helped and would best be helped but helps itself, at great cost for society. One book noted that psychotherapy was cost-effective compared to drugs in many cases. Yes, but not only in many cases. Psychotherapy *is* more cost-effective.[670]

In 2022, at a PhD defence in Copenhagen,[671] one of the examiners, psychologist Ole Jakob Storebø, made a lot out of saying that psychotherapy wasn't better than drugs for depression. When I was allowed to comment after the defence was over, I noted that it is not appropriate to refer to short-term results recorded on the Hamilton rating scale. It ignores that psychotherapy does not cause withdrawal symptoms and does not destroy people's sex lives; that pills cannot teach patients anything in contrast to psychotherapy; and that pills double the risk of suicide whereas psychotherapy halves this risk.

When my oldest daughter, psychologist Pernille Krogh Gøtzsche, and I wanted to study the effect of psychotherapy on suicide prevention, we focused on cognitive behavioural therapy because most trials had used this method. We found that psychotherapy halves the risk of a new suicide attempt in people acutely admitted after a suicide attempt.[672]

Storebø didn't reply, but the other examiner, a psychiatrist, noted that psychotherapy doesn't always work and when the patients come to him, they have already tried it in vain. Maybe so, but this cannot justify using pills that don't have clinically relevant effects and double the risk of suicide.

So, what do psychiatrists recommend when there is a suicide risk? As you have already seen in the chapter on depression, in the insane world of psychiatry, they recommend depression pills. A textbook even claimed, with no references, that the preventative effect of psychotherapy is not so pronounced as that of drugs![673]

Psychiatry is a specialty in ruins that leaves many dead patients behind while its practitioners tout great progress all the time. The psychiatrists are totally absorbed in the drug focused paradigm. In 2015, I participated in a panel at a conference with hundreds of patients in the auditorium. After I had advocated for psychotherapy instead of drugs, also for patients with schizophrenia, the psychiatrist on the panel, Professor Merete Nordentoft, a specialist in schizophrenia, remarked that drugs could not always stand alone. I turned the argument around and said that everyone should get psychotherapy and that this could not always stand alone. The audience applauded my remark. Many patients hate psychosis pills but are forced to take them.

With her permission, I shall tell the story of a young psychiatrist, Maria Grazia Turri. After having experienced the benefits of involving the family, she set up a Systemic Assessment Clinic (SAC) with another psychiatrist where they asked referred patients to bring along anyone, they felt was significant to their lives.[674] This made it easier for them to find out what the patients' problems were, and the patients and carers were highly satisfied with the process.

However, their many attempts at getting support or endorsement of the SAC from the local NHS Trust failed. They were told it was not evidence-based and were encouraged to apply for a grant. They pulled together a team of eight experts and used a year to write a 56-page grant application, which was rejected.

They then compared the outcomes for 22 SAC patients with 22 similar patients assessed in a standard fashion during the same period. Only one patient was re-referred in the SAC group versus nine in the control group for three years. Engaging people in meaningful

conversations made it possible to develop a purposeful recovery-oriented plan while the standard approach tended to make the patients chronically ill.

Turri sent a paper to the *Bulletin*, published by the Royal College of Psychiatrists, in 2016, which was rejected without peer review. She appealed, and a member of the editorial board enthusiastically replied that the paper should be sent for peer review. The reviewers were positive and suggested some revisions. She resubmitted and was told by the reviewers that her paper could now be published. However, the editor refused to accept it. He said he didn't believe the validity of the data, which is an appalling poor excuse for rejecting an important paper.

Turri then contacted the President of the Royal College of Psychiatrists who replied that the editor's opinion should be upheld and advised her not to waste any more time and energy on the matter.

Turri's view is that most of the evidence in psychiatric research has been built on quick-sand. Indeed, but unfortunately, her story is typical. The psychiatric paradigm is so harmful for the patients that leading psychiatrists need to protect their specialty by censoring unwelcome data. It took five years after the first submission before Turri's study got published.[675]

9 Forced treatment: a licence to kill

Only one of the five Danish textbooks said anything substantial about this important issue.[676] It argued that randomised trials are not possible for ethical reasons. This is not correct. As it is doubtful if force does more good than harm, it is ethically acceptable to do trials.

The book noted that the patients' aggression can be a reaction to conflicts with the staff, and that a study had pointed out that increased patient autonomy can reduce violent behaviour and the use of coercion.

This respect for the patients lasted only one page. Next, we were advised that not using psychotropic drugs for patients who are agitated, aggressive, or violent should only occur exceptionally, and the authors suggested using drugs against psychosis, depression, and anxiety, as well as antiepileptics and ECT. This "carpet bombing" with psychiatric treatments is a licence to kill or may turn patients into zombies. The book's argument that mentally ill people may lack the ability to consent or give reasonably informed consent has been rejected by the United Nations Convention on the Rights of Persons with Disabilities. It is unethical to subject patients to forced treatment.[677]

The authors mentioned that benzodiazepines, amphetamines, anabolic steroids, and testosterone can cause motor restlessness and increase aggression. It is inexcusable that they did not mention that depression pills, methylphenidate, and psychosis pills can also cause such symptoms, nor did they mention akathisia.

There needs to be a power balance in human relations, but involuntarily admitted patients are powerless and fear nothing more than forced treatment. This is a recipe for disaster. Some psychiatrists have even electroshocked patients they disliked, and doctors have regularly prescribed electroshocks for patients who were aggressive, restless, noisy, quarrelsome, and obstinate.[678]

The laws about forced treatment are problematic. In many countries, a person considered insane, or in a similar condition, can be involuntarily admitted if the prospect of cure or substantial improvement of the condition would otherwise be significantly impaired.

It is a delusion that drugs and ECT can achieve cure or substantial improvement, and this clause should be removed from the law in all nations, as its premise is false.

The other reason for using force is if the patients present a substantial danger to themselves or others. This argument is also invalid. Psychiatric drugs can *cause* suicide and violence; they cannot protect against violence unless the patients are drugged into a zombie-like state.[679] If people are dangerous, it is a matter for the police, which is the practice in Iceland.

Psychiatrists usually say that it would be impossible to practice safely without having the option of forced drugging, restraints with belts and straps, and seclusion. This is also false. Studies have shown that, with adequate leadership and training of staff in de-escalation techniques, it is possible to practice psychiatry without using force.[680]

Rare cases like forced feeding for life-threatening anorexia are already covered by other laws. And severe cases of mania, such as where the patient is busily spending his entire wealth, can be handled by an emergency clause that removes his financial decision-making rights. Furthermore, a few difficult cases cannot justify that massive harm - including many deaths - is inflicted on all the other patients, which, in addition, makes it difficult to recruit good people to psychiatry. Coercion destroys the patient's trust in the staff, which is so important for healing and for the working environment.

Some patients have learnt to avoid mentioning certain things to their psychiatrist because it may lead to additional diagnoses and more medication. This is not a healthy therapeutic relationship. It reminds us of the living conditions in the concentration camps where it was important never to provoke the guards, which could be deadly.[681] When the Polish Medical Association held their first meeting about medical experiments in the camps in Krakow in 2018, they invited me to participate. I talked to a woman who miraculously survived the experiments in Ravensbrück, and to one of Oscar Schindler's girls. A tour was arranged to Auschwitz-Birkenau, which I also visited in 1981. These are experiences you never forget, and the atrocities should never be forgotten.

If a patient says anything about having the dose reduced, she might have it increased, or might get an additional drug, with the argument that she lacks insight into her disease. Many of the about one thousand emails I have received from patients and relatives describe this catch-22 situation. I fully understand why some patients say they would rather be in prison than in a psychiatric ward. What you say or do can be used against you in both cases, but in psychiatry, the punishment can be injections of killer drugs you cannot spit out.

A colleague told me that the difference between a psychiatrist and a terrorist is that you can negotiate with a terrorist. A patient said that she likened forced treatment to rape and that there cannot be good rapes. She was raped by a man in her family when she was only nine years old and became terrified when the staff subjected her to forced treatment.

Many deeply unhappy patients have told me that they have been threatened that their sick pay or other social benefits could be taken away if they refused to take the prescribed psychotropic drugs.[682] In Denmark, this is illegal.

As for all healthcare interventions, the overriding question is whether forced treatment does more good than harm. I have no doubt it is very harmful. Mechanical restraint and ECT can be fatal; and, as explained earlier, psychiatric drugs and contact with a psychiatric ward, which often involves force, kill an enormous amount of people. It is therefore misleading when psychiatrists say that, were it not for the forced treatment, the patient might have died. Forced treatment kills.

One of psychiatry's unfortunate fads is community treatment orders (assisted out-patient treatment), which make outpatient treatment compulsory. A Cochrane review didn't find any benefits, compared with voluntary care or brief supervised discharge.[683] In clinical practice, this initiative has also failed. After the UK had introduced it, hospital admissions increased,[684] with some areas discharging 45% of the patients with treatment orders, and others none at all.

The UK mental health charity, *Mind*, has expressed serious concerns.[685] The orders mean that many people who do not wish to take drugs for the rest of their lives are no longer able to make that decision. There is no escape from this catch-22 situation. If the patient remains well, this is taken to mean that the drugs are working, and if not, forced drugging is often increased, causing even more misery and more deaths. Many people consulted by *Mind* felt the professionals acted as "Mental Health Act police officers."

If you have been a cop and used force, it can be difficult to change that role into one as a healer and advocate for the patient. This is why psychiatrists should not act as the police. Another reason is that violence breeds violence.

When I lectured in Australia in 2015, I was told that only 3–5% of the patients come off treatment orders. I met with a doctor who had been intermittently under such an order for 20 years. He gave me a copy of an evaluation by a psychiatrist who deemed him without insight because he had alerted the community to the brain-damaging effect of psychosis

drugs! Another person I met was a psychiatrist considered insane by her colleagues. She also spoke out about psychiatric drug harms. They tried to have her involuntarily confined to hospital but failed.

Lawyer Jim Gottstein convinced the Alaska Supreme Court in 2003 to rule that the government cannot drug someone against their will without first proving by clear and convincing evidence that it is in their best interests and that there is no less intrusive alternative available. Jim used scientific data to prove that it was not beneficial to treat patients forcefully.[686]

Since forced treatment is not evidence-based but culture-based, it is no surprise that practices vary enormously between countries. Involuntary hospital admissions in Europe range from 12 per 100,000 in Italy to 233 per 100,000 in Finland.[687] In Austria, mechanical restraint is used 45 times more often than in Holland, where forced drugging is also used very little.[688]

People who argue for forced treatment and involuntary detention should read the book, *Dear Luise*,[689] which I have summarised in another book.[690] It was written by Dorrit Cato Christensen, the mother of 32-year-old Louise Christensen who was killed in 2005 by a neuroleptic at the Psychiatric Centre Amager. Luise had autistic traits but functioned far too well to be autistic.

In his foreword with the telling title, *You need to be strong in order to be vulnerable*, former Danish Prime Minister Poul Nyrup Rasmussen describes the book as heart-breaking. It is. If doctors consider becoming psychiatrists and can get through it without crying, they should find themselves another job. Rasmussen's foreword starts with: "Mom, won't you tell the world how we're treated?" This was Luise's last request before she died.

Luise's best friend, who stayed in the room next to her, suddenly collapsed on the floor and died within a few minutes. Luise was completely shattered and all she said to her mother was: "I shall be next," which came true six months later. She knew the psychiatrists would kill her. She survived for a while because she tolerated the overdosed psychosis pills so badly that she vomited most of them up. At last, they broke her defenses with a lethal injection of a depot drug.

Luise and Dorrit had protested many times against the too high dose, but the level of ignorance, incompetence, and lack of respect for people who knew a lot about the drugs was huge. Dorrit did everything she could to prevent Luise getting overdosed. She was a slow metaboliser, and Dorrit had begged the psychiatrists never to use a depot injection. They didn't listen.

Every year, on the anniversary of Luise's death, there is a demonstration in front of Psychiatric Centre Amager arranged by the organisation *Death in Psychiatry*, which Dorrit started. Sometimes there are around 20 relatives of the psychiatric patients killed in the same way.

Dorrit's book about her daughter is one long horror story of wrongdoing in psychiatry. Not even after Luise's death was there any justice. The system's arrogance, both before and after her death, was unbelievable. When Dorrit complained to the authorities, they replied that Luise had received the highest standard of specialist treatment while it congratulated itself with its first-class homicide and called it a "natural death."

Dorrit's book describes virtually everything that is wrong with psychiatry including making incorrect diagnoses that result in death. Whenever I open it, I get overwhelmed with

sadness. I personally know Dorrit and know that many patients are abused and die under similar circumstances as Luise.

Being treated humanely is difficult. If you panic and go to a psychiatric emergency ward, you will probably be told you need a drug, and if you decline and say you just need rest to collect yourself, you might be told that the ward is not a hotel.[691]

This is bad medicine. Impending psychoses can sometimes be fended off if we provide patients with the shelter and rest they need. There should be 24-hour support facilities without compulsion, so that patients in acute crisis can avoid the dangers of mainstream psychiatry.[692]

Psychiatry seems to be the only area in society where the law is systematically being violated all over the world - even Supreme Court and Ombudsman decisions are being ignored, e.g. in Alaska and Norway.[693]

I got access to 30 consecutive cases from the Psychiatric Appeals Board in Denmark and found that the law had been violated in every single case.[694] All 30 patients were forced to take psychosis pills they didn't consent to, even though less dangerous alternatives could have been used, e.g. benzodiazepines.[695] The psychiatrists had no respect for the patients' experiences and views. In all 21 cases where there was information about the effect of previous psychosis pills, the psychiatrists claimed a good effect whereas none of the patients shared this view.

The harms of prior medication played no role either in the psychiatrist's decision making, not even when they were serious. We suspected or found akathisia or tardive dyskinesia in seven patients, and five expressed fears of dying because of the forced treatment. An expert confirmed our suspicion that a patient had developed akathisia on aripiprazole (Abilify) but on the same page, the expert - a high-ranking member of the board of the Danish Psychiatric Association - recommended forced treatment with this drug even though it was stopped because of the akathisia.

The power imbalance was extreme. We doubted the psychiatrists' diagnoses of delusions in nine cases, and there is an element of catch-22 when a psychiatrist and a patient disagree. According to the psychiatrist, it shows the patient has a lack of insight into the disease, which is a symptom of mental illness.

The abuse involved psychiatrists using diagnoses or derogatory terms for things they didn't like or didn't understand; the patients felt misunderstood and overlooked; their legal protection was a sham; and the harm done was immense.

The patients or their diseases were blamed for virtually everything untoward that happened. The psychiatrists were not interested in traumas, neither previous ones nor those caused by themselves or their staff. Withdrawal reactions were not taken seriously - we didn't even see this term being used although many patients suffered from them.

Jim Gottstein and I wanted to do a similar study of 30 consecutive petitions from Anchorage, but we were met with so many obstacles that it took over four years of litigation before Jim was granted access to the redacted records. With US psychiatrist Gail Tasch, I published our findings in 2023. Involuntary medication orders were requested for the 30 patients, and we found that the legal procedures can best be characterized as a sham where the patients are defenceless.[696]

In violation of previous Supreme Court rulings, the patients' experiences, fears, and wishes were ignored in 26 cases even when the patients were afraid that the neuroleptics

might kill them or when they had experienced serious harms such as tardive dyskinesia. Several of the psychiatrists obtained court orders for administering drugs and dosages that were dangerous. The ethical and legal imperative of offering a less intrusive treatment was ignored, e.g. benzodiazepines were not offered. And the psychiatrists claimed, contrary to the evidence, that psychotherapy does not work. They never provided psychotherapy or family therapy.

It is a serious transgression of the law and of professional ethics when psychiatrists exaggerate the patients' symptoms and trivialise the harms of the drugs to maintain coercion, but this often happens, and the patients' files can be misleading or wrong, or changed after a drug induced suicide.[697] In this way, the psychiatrists can be said to operate a kangaroo court, where they are both investigators and judges and they lie routinely in court about the evidence.[698]

When the patients complain about this unfair treatment, which isn't allowed in any other sector of society, it is the same judges (or their friends who won't disagree with them) whose evidence and judgments provide the basis for the verdicts at the appeal boards. It doesn't matter in the slightest what the patients say. As they have been declared insane, no one finds it necessary to listen to them. This is a system so abominable that it looks surreal, but it is the reality all over the world.

Most patients on psychosis drugs want to come off them, but as many are forced to take them, in the worst cases as depot injections to ensure they don't "cheat" by spitting out the tablets when the staff have gone, this is very difficult to accomplish.

The fundamental human right to equal recognition before the law applies to everyone, including people with mental disorders. This is clear from the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the United Nations Convention on the Rights of Persons with Disabilities, which have been ratified by virtually all countries.

In 2014, the UN Convention specified that member states must immediately develop laws and policies to replace regimes of substitute decision-making by supported decision-making, which respects the person's autonomy, will and preferences. This means that unsoundness of mind and other discriminatory labels are not legitimate reasons for the denial of legal capacity. And the United Nations Special Rapporteur, Dainius Pūras, a Lithuanian psychiatrist, called upon all nations to make forced treatment illegal, but not a single country has done anything about it during these ten years.

Recently, the UN Office of the High Commissioner on Human Rights declared Pūras's work "groundbreaking," but leading psychiatric organisations have been hostile and disdainful. A common strategy is to regard the special rapporteur, and by association, the United Nations, as unscientific and biased, while current practice in psychiatry is presented as intrinsically scientific and ethical.

An instructive article has analysed the reactions by psychiatric organisations to Pūras's report.[699] They included the usual falsehoods, e.g. that antipsychotics emptied the asylums and made it possible for people to live normal lives, and that "pharmacological treatments have been shown to reduce the risk for suicide" (avoiding mentioning which drugs they were, but there are none), with no references, only vague statements like "an extensive body of data." The correct statement that psychiatry is guilty of human rights violations was called "absolutely slanderous as it attacks an entire professional community without distinction and - what is more - is absolutely not evidence-based."

How long will we allow the psychiatrists to continue with their lies, fatal mistakes, corporate denial, cognitive distortions, and suboptimal practice? It is our duty to free our citizens from this deadly violation of human rights. Most recently, in October 2023, the WHO joined forced with the UN Office of the High Commissioner for Human Rights and issued the publication, *Mental health, human rights and legislation: guidance and practice*.[700]

Psychiatrist Niall McLaren wrote: "We know that, at the slightest hint of a threat, the psychiatry/drug company axis will run squealing to their friends in government to drop a very large hammer on the upstarts … There's no doubt that mainstream psychiatry worldwide will have a collective fit when they see what non-psychiatrists have planned for them ... we can be sure of one thing: given its record, institutional psychiatry will not give in with good grace. I mean, look at the journal editors: they don't even want to know the WHO or OHCHR exist. They don't realise that the Guidance, as issued recently, is a gun pointing at psychiatry's collective head. It's not an encouraging start."[701]

Silas Dam killed himself in 2023, when only 24 years old.[702] But in his short life, he made a contribution that will benefit many psychiatric patients in Denmark. He found that his belt restraint was unjustified, and although it was approved by both the district court and the high court, he brought his case to the European Court of Human Rights in Strasbourg, helped by a lawyer. This resulted in a settlement with the Ministry of Health obliging the government to amend the Psychiatry Act, so that the rights of psychiatric patients subjected to belt restraint were improved. His suicide note read: "Psychiatry killed me, belt restraint killed me, forced medication killed me." He added: "Share my story."

If you are still not convinced, you should read *The Zyprexa papers* by Jim Gottstein.[703] It is a book about illegal, forced drugging that destroyed patients. Psychiatrists, lawyers, and Eli Lilly lied shamelessly, and the judges didn't care. I experienced this first-hand as Jim's expert witness when I visited him in Anchorage in 2016. He needed to go to the Supreme Court in Alaska before he got any justice, and he ran a great personal risk by exposing documents that were supposed to be secret.

I have argued extensively in books, articles, and lectures why forced treatment in psychiatry cannot be defended, either on ethical, legal, or scientific grounds,[704] and I co-authored a damning report with Jim and others in 2023.[705]

But leading psychiatrists continue to ignore or distort the facts. The chairman of the Norwegian Psychiatric Association, Ulrik Fredrik Malt, claimed in a newspaper in 2019 that the risk of dying is six times greater if a patient with schizophrenia does not take neuroleptics.[706] I replied that I feel sorry for Norwegian patients who need to consult psychiatrists like him.[707]

10 Withdrawal of psychiatric drugs

Doctors have made hundreds of millions of patients dependent on psychiatric drugs. One should not prescribe such drugs without a tapering plan, but I have not heard of a single patient who was put on a psychiatric drug after having been given adequate information about its harms, including abstinence symptoms, and a tapering plan. A recent survey showed that only 1% of New Zealanders on depression pills had been told anything about withdrawal effects or addiction.[708]

Doctors didn't learn how to stop drugs safely but learned a lot about starting them and ignoring the troubles they cause by blaming the disease and the patient.

It is a testimony to the absurdity that psychiatrists have carried out tens of thousands of drug trials but only a handful of studies about safe withdrawal. Not only has there been a scarcity of good research for over 150 years on how to come off addictive drugs in the best possible way - including opium, bromides, and barbiturates - but in all these years, doctors have ignored when their patients complained of difficulties in coming off their drugs.

Then there is the money. It is much quicker to renew a prescription than to stop an addictive drug and it generates a much bigger income. And doctors may feel disrespected when patients ask to come off the drugs they have instituted. A common notice in hospital records is: "The patient doesn't want drugs. Discharged." It is almost like: "So, you don't like my drugs? Then you don't like me either. Good bye!"

A patient told me that she was prescribed happy pills after a traumatic event without adequate information about side effects - as drug harms are euphemistically called - and when she wanted to stop a year later, as she felt the drug wasn't helpful, her psychiatrist convinced her she needed a higher dose and warned her that stopping the drug could lead to chronic depression.[709] She became more and more lethargic and indifferent to everything, and when her psychiatrist had long-term sick leave, she got support from a psychologist to taper off the drug, which she had been on for 3.5 years. When the psychiatrist returned, she was insulted that her patient felt much better without the drug and declared that she could not help her when she didn't want drugs. This psychiatrist had a close relationship to a manufacturer of happy pills.

Patients are mostly left to fend for themselves, but few can master this. They therefore share their experiences on the Internet, e.g. on theinnercompass.org created by Laura Delano, and on social media.

What we need the most in psychiatry are withdrawal clinics, with easy and quick access free of charge, and education about the harmful effects of psychiatric drugs, how to stop them, and how to avoid starting them. Public investment in such clinics would lead to fewer disability pensions, much fewer deaths, much healthier citizens, and fewer serious crimes.

Nurses, psychologists, social workers, teachers, and other non-prescribing people have often been taught that their task is to push people to get a diagnosis and to comply with the prescribed medication. They should be taught to help the citizens avoid psychiatric diagnoses and drugs.

The biggest obstacles to withdrawal are ignorance, false beliefs, fear, pressure from relatives and health professionals, and practical issues like the lack of medicines in appropriately small doses.

Most of the advice in psychiatry textbooks about how to withdraw patients from psychiatric drugs is wrong and often directly dangerous. In long lists of withdrawal symptoms, the most serious harms, akathisia, suicide and violence, were missing. And although the

abstinence symptoms are very similar for depression drugs and benzodiazepines,[710] they were not called abstinence symptoms for depression drugs.

None of the books explained that the binding curves for psychiatric drugs are hyperbolic, and that the tapering therefore needs to be exponential, with very small dose reductions by the end.[711] The most important reason why withdrawal attempts often fail is that doctors taper far too quickly and in a linear fashion. Moreover, few doctors understand that withdrawal symptoms and disease symptoms are often the same. When patients deteriorate during withdrawal, psychiatrists, other doctors, social workers and relatives will usually tell them that their symptoms demonstrate that they still need the drug.

I invented the term "abstinence depression" for withdrawal symptoms that mimic a depression. It is a depression that occurs in a patient who is not currently depressed but whose drug is stopped abruptly or over a few weeks. Its hallmark is that the depression symptoms come quickly (depending on the half-life of the drug or its active metabolites) and disappear within hours when the full dose is resumed. Reintroducing the drug can therefore be regarded as a diagnostic test separating an abstinence depression from a true depression, which does not respond promptly to a depression pill.

A cold turkey trial showed the difference very clearly.[712] Patients who were well suddenly had their maintenance therapy changed to a double-blind placebo for 5–8 days at a time unknown to them and their clinicians. The authors' criteria for depression were fulfilled for 25 of 122 patients on sertraline or paroxetine. I worked out that the expected number of patients relapsing in such a short time interval was zero,[713] which suggests that none of the 25 patients would have "relapsed" if they had not been exposed to a cold turkey. I based this on a study of 362 high school students who had experienced one or more episodes of depression.[714] Of the patients who recovered, 5% relapsed within 6 months and 12% within a year, which suggests a rather constant relapse rate over time. Using these data, I calculated what the expected number of patients relapsing is. This is 122 x 12% x 6.5/365 = 0.03.

The absurdities in the textbooks were endless and demonstrated that the psychiatrists confuse withdrawal symptoms with relapse. Two books claimed the patients do not become dependent on depression pills, and one of them noted that, because of this, relapse should not be misinterpreted as withdrawal symptoms! This is also how most psychiatrists argue in clinical practice and in their scientific articles.

Two textbooks claimed that if the drug is stopped too early, it increases the risk of relapse, and this misconception led to harmful recommendations of long-term treatment. A continuation phase of 6–12 months after remission of depression was advised in the textbooks, and the longer, the better, e.g. by severe depression with imminent suicide risk. This advice is deadly.

If a patient had had two depressions within 5 years, the doctor should consider continuing with the drug for an extra year; if three depressions, for 5–10 years or lifelong; if onset after 50–60 years of age, the treatment should also be lifelong because the risk of recurrence was said to be almost 100%. It was also claimed that an excellent preventative antidepressant effect is achieved. This cannot happen because the drugs don't work (see Chapter 2 on depression).

A textbook recommended continuing with the drug for the same number of years as the number of depressive episodes. Even if we imagine we had a drug that worked, it is bizarre. It means that the poorer the effect, including no effect, the longer the patient should take the drug. If seven depressions, the patient would be "sentenced" to an additional seven years on the pill.

One textbook recommended maintenance treatment already after a single manic episode, for 2–10 years or lifelong. The standard in clinical practice is life-long treatment.

A big error in the textbooks was that they listed short time intervals where withdrawal symptoms can occur. They can occur at any time, e.g. if the patient becomes stressed, and a review showed that the longer one is on the drugs, the higher the probability of withdrawal effects when one stops.[715] This review found that the overall rate of withdrawal effects was 56%, with 25% of the patients experiencing severe withdrawal.

In 2024, *The Guardian* reported that only 15% develop withdrawal symptoms and that only 3% experience severe symptoms,[716] referring to a study in *Lancet Psychiatry*.[717] Psychiatrist Carmine Pariante triumphantly declared in his headline that "The myth that antidepressants are addictive has been debunked – they are a vital tool in psychiatry."[718]

The problem with this declaration was that it was wrong. And Pariante conveyed more falsehoods, e.g.: "For those they do help, antidepressants undoubtedly improve depression and reduce the risk of suicide." He also claimed that, in his 33 years of clinical practice, he could recall those who had difficulty stopping "on the fingers of one hand." Well, there is none so blind as he WHO WILL NOT SEE.

The study was unreliable, primarily because what was reviewed were short-term placebo-controlled trials funded by industry.[719] The industry is not interested in finding severe harms in their studies, they ignore them, and assessing withdrawal effects is rarely an outcome in industry trials.

In 2014, I co-founded the Council for Evidence-based Psychiatry in the UK,[720] established by filmmaker and entrepreneur Luke Montagu, heir to the Earl of Sandwich, who had suffered horribly from withdrawal symptoms for many years after he came off his psychiatric drugs.

I gave a lecture at the inaugural meeting in the House of Lords explaining why the use of psychiatric drugs do more harm than good. We got a lot of press coverage, and three months later, I was attacked by the silverbacks of British psychiatry in *Lancet Psychiatry*.

Their article is full of *ad hominem* attacks and false information about miraculous drug effects, including the usual mantras that depression drugs protect against suicide and that people who criticise psychiatry are "anti-psychiatry."[721] It was very primitive, and I pointed out their errors and that they had no valid arguments.[722]

These people were at the top of their profession and yet they held views in direct contrast to the science. They claimed that SSRIs are some of the safest drugs ever made; that their adverse effects are rarely severe and that we should ignore "severe experiences to drugs," which they dismissed as anecdotes that might be distorted by the "incentive of litigation." Furthermore, they said the pills are highly effective claiming an impressive effect on recurrence, with a number needed to treat to benefit one patient (NNT) of around three. They did not understand that the trials did not assess recurrence but abstinence depressions in the placebo group. As only two patients are needed to get one with withdrawal symptoms when a drug is stopped,[723] there cannot exist an NNT to prevent recurrence, only a number needed to harm (NNH), which is two.

I mentioned Luke's name in 2015 in an invited article for the *Daily Mail* where I noted that psychiatric drugs are the third major cause of death.[724] The UK Royal College of Psychiatry reacted the same day: "Sadly, articles of this nature can do more harm than good, as there is a real risk that they can discourage people from seeking or continuing treatment. This is dangerous, as untreated depression has roughly the same effect on mortality as smoking and can lead to suicide."[725] They urged me to publish my data in peer-reviewed

journals so that the claims could be independently scrutinised. What is wrong with publishing the data, which come from the published literature, in a book and do calculations on them?

The editor made many changes to my article and insisted that I added this statement: "As an investigator for the independent Cochrane Collaboration - an international body that assesses medical research - my role is to look forensically at the evidence for treatments."

Even though my article came out two weeks after I had published my first psychiatry book where all the evidence was, my research was publicly denigrated by the Cochrane leaders who uploaded a statement that is still up.[726] They said my statements about psychiatric drugs and their use by UK doctors could be misconstrued as indicating that I was conducting my work on behalf of Cochrane. They also said that my views on the benefits and harms of psychiatric drugs were not those of the organisation.

I was now in an infight with my own organisation. Cochrane has three mental health groups and they have published hundreds of misleading reviews of psychiatric drugs because the authors did not pay enough attention to the flaws in the trials.[727] The two most important issues are these:

The source material is mainly industry-supported trial reports in medical journals, which are highly misleading compared to the clinical study reports the companies have submitted to drug regulators,[728] with biased analyses of the benefits and omission of serious harms. Even half of all deaths are missing.[729]

Cochrane authors ignore that almost all placebo-controlled trials are biased because the patients were already in treatment with a similar drug before randomisation and are therefore exposed to cold turkey effects.

Obviously, Cochrane as an organisation cannot have any "views" about psychiatric drugs that carry more weight than those of a researcher who has studied the research in detail. But their tactic of disavowing my evidence-based conclusions worked, of course. Eminence always beats evidence. Five days after they uploaded their statement, *BMJ* published a news item, *Cochrane distances itself from controversial views on psychiatric drugs*.[730] This was an abuse of the term "controversial." It is not controversial that scientists tell the public what they have seen, in fact, they are expected to do exactly that, without censorship.

Both then and subsequently, Cochrane preferred to support the psychiatric guild and the drug industry rather than honest science, and this was widely abused by the psychiatrists. David Nutt, one of the silverbacks, said during a lecture in New Zealand in February 2018 that I had been kicked out of Cochrane. He was seven months premature.[731] Nutt was previously the UK's main drug adviser to the government but was sacked for claiming that ecstasy - a recreational drug also called MDMA, an amphetamine derivative - is no more dangerous than riding a horse. I call him David Nuts.

Luke wrote about his own psychiatric "career" in the *Daily Mail* article. His symptoms were of such a nature and severity that at first, I found it hard to believe him. I had never learned about anything remotely similar to his torment during my medical studies or later.

Another of my colleagues, psychiatrist Mark Horowitz, would probably also have disbelieved the many horrible withdrawal symptoms his patients told him about, if he had not experienced similar horrors himself when spending years trying to come off his depression drug.[732] Mark wrote to the members of the Critical Psychiatry Network: "Duloxetine, paroxetine and venlafaxine are vicious drugs to get off and I have seen every possible horror from this including akathisia, muscle spasms, and suicide. I have seen people who have taken 3–5 years to come off each of these drugs."

Luke had no psychiatric condition whatsoever when he fell into the invisible psychiatric drugging trap. He had a sinus operation and probably reacted badly to the anaesthetic, but his family physician told him he had a chemical imbalance in the brain and put him on various depression pills that didn't help. None of the doctors and psychiatrists listened when Luke told them it had begun with the sinus operation.

As it so often happens, Luke reluctantly concluded there was something wrong with him and every time he tried to come off the drugs, he felt so awful that he went back on them and thought he needed them. After a psychiatrist had given him four new drugs, including a sleeping pill, he failed to realise he had become "as dependent as a junkie on heroin."

Luke was exposed to serious medical malpractice. At an addiction clinic, his psychiatrist advised him to come off the sleeping pill right away and within three days he was hit by a tsunami of horrific symptoms. This was the start of nearly seven years of hell. It was as if parts of his brain had been erased. When he recovered, he still had a burning pins and needles sensation throughout his body, loud tinnitus, and a feeling of intense agitation. When I last met with Luke, in June 2019, he was still suffering from withdrawal symptoms.

Luke founded the All-Party Parliamentary Group on Prescribed Drug Dependence (APPG), which successfully lobbied the British Government to recognise the issue and he also got support from the British Medical Association and the Royal College of Psychiatrists. In 2019, the APPG and the Council for Evidence-based Psychiatry published detailed guidance about withdrawing psychiatric drugs.[733]

How to do it and how not to do it

The overlooked withdrawal problem was the reason why I started an informal critical psychiatry network in Denmark with psychologist Allan Holmgren in 2014. Four of us wrote a short guideline about helping patients withdraw, with an abstinence chart to record daily symptoms and tips about how to produce the small doses that are needed. I also made a list of people worldwide who are willing to assist in the process.[734] Some of us have tried to help the patients in various ways, e.g. by publishing a newspaper article telling people that psychiatric drugs are not the solution to their problem,[735] which we translated into English.[736]

In 2016, I co-founded the International Institute for Psychiatric Drug Withdrawal[737] in Göteborg, and in 2020, I published the book, *Mental health survival kit and withdrawal from psychiatric drugs*,[738] to help the patients taper off the drugs safely. It has appeared in nine languages and was serialised on Mad in America where it can be read for free.[739] Volunteers found it so useful that they translated it into Spanish, French and Portuguese and I offer it for free in these languages on my institute's website.[740] It has also appeared in Danish, Swedish, Dutch and Italian.

In 2024, Mark Horowitz and David M Taylor published a detailed guidance book about withdrawal.[741]

As doctors are rarely helpful, it is often psychologists, other therapists, pharmacists, friends and relatives that help the patients come off their drugs.

It is a huge asset if the patient can find a person who has succeeded with withdrawal - a recovery mentor - and involves that person in the withdrawal. As a recovery mentor will rarely be available on a daily basis, other support people are needed. The feeling of security and that someone cares can have a strong healing effect.

Those psychologists that have not accepted the myths of biological psychiatry can also be very helpful. It can be overwhelming when the emotions, which have been suppressed for so

long, come back, and it can be crucial to get psychological support to handle the transition from living emotionally numbed to living a full life.

When in the midst of painful psychiatric drug withdrawal, the patients' brain is in a state of drug-induced crisis, and it is truer than ever that they cannot believe what their mind tells them. However, they will often feel they are themselves and will explain away their odd behaviour if confronted with it - denying they have become irritable, agitated, hostile or difficult in other ways - and will react with anger over such "accusations."[742]

This is why it is essential that patients are not alone, and that close relatives or friends observe them carefully. When patients have left suicide notes, only very rarely is there any indication that the drug was the problem; the patients don't know this and think they have gone mad. It can therefore be dangerous if the patient's false explanations are accepted, and the patient should allow friends and family to contact the therapist if they are concerned.

It often requires strong determination and patience to come off the drugs. It can usually be done within a few months, but the record for psychiatrist Jens Frydenlund is eight years for an SSRI. He has worked with drug addicts for decades, and, like other psychiatrists, he says it is much easier to stop heroin than to stop a benzodiazepine or an SSRI because the abstinence symptoms with heroin disappear rather quickly. It is not surprising that some patients say the withdrawal was worse than their depression.[743]

It is often huge work to help a patient get through withdrawal, and it doesn't end there. The support person should summarise the process and the most important symptoms together with the patient who should be offered continued support. There is a risk of falling back in the drug trap if a situation is stressful, which can cause some of the withdrawal symptoms to return, even long after a successful withdrawal. It can take years before the brain becomes normal again, and sometimes, it will never happen because the brain has been irreversibly damaged.

There is also an equity issue. Patients who have more resources are freer to take time off work, to pay for therapists helping them withdraw, and to be financially viable in the process. Thus, psychiatry harms the poor more than it harms the rich.

One should not try to taper off a patient who doesn't have a genuine wish of becoming drug-free. It is unlikely to work. But this should not be used as an excuse for doing nothing. We need to explain to the patients that long-term treatment is very harmful and should try to persuade them to start a withdrawal process. Unfortunately, there is a huge problem with drug-seeking patients who have been convinced by pharma propaganda to insist on taking drugs, and many prescribers hide behind "patient choice" and continue harming their patients.

In Holland, former patient Peter Groot and professor of psychiatry Jim van Os have taken a remarkable initiative. A pharmacy in Amsterdam produces tapering strips, with smaller and smaller doses of the drug, making it easier to withdraw. Doctors from any country can order the strips from the website taperingstrip.org.

Their results are impressive. In a group of patients on depression pills, 62% had previously tried to withdraw without success, but after a median of only 56 days, 71% of the 895 patients had come off their drug.[744]

In 2023, I wrote about this on Mad in America and explained how one can make small doses that are not commercially available without ordering tapering strips.[745]

It is important to get a successful start. It is often best to remove the most recently started drug,[746] as withdrawal gets harder the longer the patient has been on a drug. Lithium

and psychosis pills should be withdrawn early on, as they cause many harms. As withdrawal can cause sleeping problems, it is a good idea to remove sleep aids last.

With few exceptions, it is not advisable to withdraw more than one drug at a time, as it makes it difficult to find out which drug causes the withdrawal symptoms.

It is rarely a good idea to substitute one drug for another, even if the new drug has a longer half-life in the body. A switch can lead to additional withdrawal problems because the two drugs may not target the same receptors, or to overdosing, as it is hard to know which doses should be used in the transition phase. But it may be necessary if a tablet or capsule cannot be split.

It is generally not advisable to introduce a new drug, e.g. a sleeping pill if the withdrawal symptoms make sleep difficult. It is better to increase the dose a little temporarily.

The last small step can be the worst, not only because of physical issues but for psychological reasons. The patient may ask him- or herself: "I have taken this pill for so long; dare I take the last small step? Who am I when I don't take the pill?" The doctor may laugh and tell say it's impossible to have withdrawal symptoms when the dose is so low.[747] If such a "know-it-all" guy is involved in the withdrawal, the patient should find another doctor.

The story of Stine Toft, a 27-year-old Danish woman, was so devastating, yet also so typical, that I published it on Mad in America.[748] She has never been manic, apart from the time when she received a depression pill, but nonetheless got the diagnosis bipolar. She was seriously harmed. She was told her condition would last for the rest of her life; she took depression pills, antiepileptics and a psychosis pill; gained weight, 50 kg; lost about 14 years of her life to psychiatry; lost her husband; came close to suicide; and ended up on disability pension.

Stine's next husband saved her. He asked what the sickness was all about, because he couldn't see it. But she now suffered from medication spellbinding. It took a year and a half before she surrendered and agreed to withdraw the medication, which was excruciating because she didn't receive the necessary guidance. It took two and a half years. After this, she found two of my books and realised that everything she had experienced was well known and perfectly normal. It was shocking to her to read about how it is normal practice to be exposed to the hell she had been through, but also liberating to discover that she wasn't sick and that there was nothing wrong with her.

Stine is doing well today. She became a coach and a psychotherapist and has helped many patients taper off their depression pills. She no longer sees her family. They maintained the claim that she was ill and just needed to take her medication.

Stine lectures but finds it difficult to get the message out. She has lectured for Psychiatry in the Capital Region about being bipolar, which was easy. People like to see a sick person and hear her story. But a psychiatric survivor's success story that calls the whole system into question is not considered interesting, or rather, it is considered threatening for the profession.

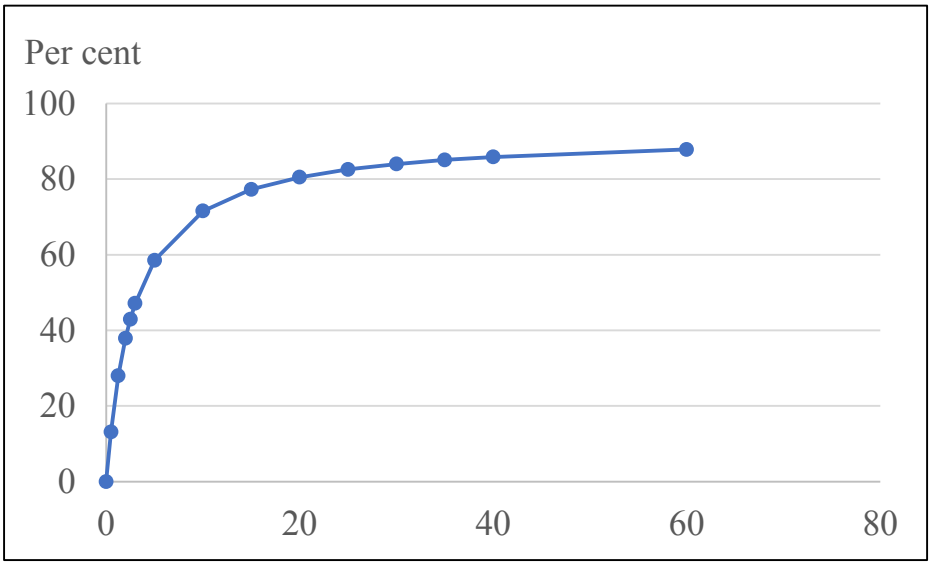
In 2019, Stine suggested to the patient organisation "Better Psychiatry" in her hometown that they invite me to lecture. The chair didn't know who I was and introduced the meeting by saying that psychiatry needed more money. I said I wasn't sure this was a good idea. If more money came in, even more diagnoses would be made, even more drugs would be used, and even more people would end up on disability pension.[749]

It was worthwhile to write the book about withdrawal. The first chapter is: *This book might save your life*, and I have received many emails telling me it saved someone's life.

Most doctors know very little about withdrawal symptoms and about how to taper off them relatively safely, with the least possible harms,[750] and if they taper at all, they do it too quickly. In this, they are supported by the authorities. In 2019, the Danish Board of Health issued a guideline about depression pills to family doctors. The sender was *Rational Pharmacotherapy*, but it wasn't rational, it was dangerous. As I knew from earlier experiences that you get nowhere by complaining to the authorities, I warned people against the guideline in a newspaper.[751]

The Board of Health was given the opportunity to respond but declined - a sign of the arrogance at the top of our institutions. A psychiatrist and a clinical pharmacologist had contributed to the guideline, but they didn't seem to know that binding curves for drugs to receptors are hyperbolic. The curve is very steep in the beginning when the dose is low, and it flattens out and becomes almost horizontal at the top (see figure, numbers on the x-axis are citalopram doses).

Citalopram is recommended to be used at dosages of 20 or 40 mg daily, but even at a dose as low as 0.4 mg, 10% of the serotonin receptors are still being occupied.[752] This means patients may experience withdrawal symptoms when they go from that small dose to nothing.



(Courtesy of Mark Horowitz)

The Board recommended halving the dose every two weeks, which is risky. Since virtually all patients are overdosed, they might remain on the flat part of the binding curve after the first dose reduction and may not experience withdrawal symptoms. But even this might cause problems because psychiatric drugs stimulate several receptors, and we don't know the binding curves for all these.

The next time, when going from 50% of the starting dose to 25%, things can go wrong, and if there are no withdrawal symptoms, they will almost certainly appear at the 12.5% dose. It is also too fast to change the dose every two weeks. The physical dependence on the pills can be so pronounced that it takes months or years to fully withdraw from the pills.

A withdrawal process should respect the shape of the binding curve, and therefore must become slower than by halving the dose at each step. This can be obtained by removing a certain percentage of the previous dose, e.g. 10%. Then, the first step is 90%, and from 50%, you don't reduce to 25% but only to 45%. If you reduce by 10% twice a month, it will take 11 months before you come down to 10% of your starting dose, so if you are on four drugs, it may take you four years to become medicine-free if you don't try to go faster than this.

These principles have been known for decades and my colleagues and I have written repeatedly about them in Danish newspapers and elsewhere since 2017.[753] And in 2019, eight months before the Danish Board of Health published its guideline, they were explained in an instructive paper in *Lancet Psychiatry*.[754]

In 2021, when psychiatrists Christoffer C. Lundsgaard and Poul Videbech nonetheless advised to halve the doses every second week in a "State of the Art" article in the *Journal of the Danish Medical Association*, I explained again that this advice is dangerous.[755] In their reply, they changed subject and noted that I arranged "expensive" (they were cheap) courses in withdrawal and that I sold books (I only wrote one) about this.[756]

Protecting the psychiatric guild and sacrificing the patients

Psychiatric drugs are the holy grail for psychiatrists. There are therefore huge push-backs from the psychiatric guild and its allies when you tell people the truth about the drugs and lecture about how to safely withdraw from them and get a better life.

I lobbied speakers on health in the Danish Parliament for over ten years and they were always positive when I explained why major changes are needed in psychiatry, with less use of drugs and with withdrawal initiatives. But they never dared challenge the psychiatrists who were quick to tell them that psychiatry was outside their area of expertise. It is also convenient for politicians that there is a profession that deals with the most disturbing elements in our societies and exert tight social control over them.

In 2016, there was a hearing in Parliament about why withdrawal from psychiatric drugs is so important and how we should do it, which was the title for my talk. There wasn't a single psychiatrist with experience in withdrawal on the programme. The only psychiatrist was Bjørn Epdrup who explained why psychosis pills are needed and said he could see schizophrenia on a brain scan, which is not true.[757] Epdrup left the meeting before anyone could confront him with his claims. The only thing that can be seen on a brain scan is the shrinking of the brain that psychosis pills have caused![758]

In 2017, I gave an invited talk at a meeting about overdiagnosis and overtreatment in psychiatry in Sherbrooke, Canada. Even though most of audience were psychiatrists, 74 of the 84 participants reported afterwards that my presentation had responded to their needs. I had not expected this, particularly not after the discussion, which was tense.

I felt a change was on its way. Two months later, Allan Holmgren and a political party arranged a conference in Parliament, *A psychiatry without drugs*. Bob Whitaker lectured about the psychiatric drug epidemic and I was equally outspoken: *The myth about biological psychiatry; the use of psychiatric drugs does far more harm than good*.

But I became disappointed. The bad business just continued.

In 2017, I held a full-day course about psychiatric drug withdrawal in Copenhagen. This was too much for the believers in biological psychiatry. *MIND*, the member journal of the most

influential organisation for psychiatric patients in Denmark, refused to publish an ad for the course even though it was both for professionals, patients, and their relatives.[759]

At first, I called *MIND*'s journalist, Henrik Harring Jørgensen, who was responsible for ads. He was very uncomfortable and said he shouldn't get involved in the debate about psychiatric drugs. I explained that whatever one might think about psychiatric drugs, many patients wanted to quit, but couldn't get any help, which was why we offered the course.

Jørgensen needed a green light higher up, and I knew that *MIND*'s chairman, Knud Kristensen, was very fond of drugs, which he always praised in the media when I criticised them. In a radio debate, he argued that some of his members had said that depression pills had saved their life. I replied it was an unfair argument because all those the pills had killed couldn't raise from their graves and say the pills killed them.

When I lectured for *MIND* in Copenhagen a year earlier, Kristensen had travelled from the other end of the country to chair the meeting and to ask questions. He clearly disliked me, and his questions were unfriendly. However, the patients said that what I had told them was true, and they had experienced themselves how difficult it is to stop psychiatric drugs.

I sent my ad to Jørgensen, but *MIND*'s headquarters ignored me. I sent several emails they didn't respond to and called several times and was switched to Jørgensen by the secretary who said he was in his office, but he didn't pick up the phone.

When the deadline for the ad was only a few days away, I went to *MIND*'s headquarters to get an answer. Documentary filmmaker Janus Bang had followed my work for two years, so I took him and his crew with me to record the event for later use. We did not announce our visit in advance, of course.

MIND's director, Ole Riisgaard, treated me very rudely and condescendingly, like when a school master reprimanded a naughty student in the 1950s. He knew about my ad but needed Kristensen's approval.

The next day, he wrote they would publish my ad. He added that, "Considering your very bad and totally unacceptable behaviour yesterday where you showed up without agreement or permission, and with cameras turned on filming *MIND*'s staff, several of whom are mentally vulnerable and employed under special provisions, the condition for bringing the ad is that you, before the deadline, will send me a written (signed) guarantee that none of *MIND*'s employees will participate in any kind of broadcast without written consent."

The cameras were not turned on, and we had been calm and polite. The only people displaying bad behaviour were Riisgaard and Jørgensen, which we recorded with a hidden microphone, as we find it important to document bullying and other abuses of power in matters of importance for patients' health and survival. Janus wrote to Riisgaard that his people had followed me for some time and therefore also to *MIND*, and that he had asked for permission to film, which was granted. As soon as this was rejected on another floor, the film work stopped. The only one who was filmed was me.

I wrote to Riisgaard that since Jørgensen never replied, we had no other option than to visit *MIND*'s headquarters. I took issue with his explanation that the reason I did not get a reply was that *MIND* was busy. I noted it would have taken Jørgensen a few seconds to respond OK when I sent him the ad. I also wondered why *MIND* would not give a helping hand to the many of their members who wanted to stop psychiatric drugs but had been unable to get any help from their doctor.

The day before we visited *MIND*, Riisgaard had received an email from a local branch (copied to me) explaining that they had discussed my correspondence with Jørgensen about an ad for a withdrawal course. "Based on this, it looks as if some form of censorship is being

applied. It is our impression that many of our members are interested in Peter Gøtzsche's work. We do not understand this attitude."

So, what do leaders do when they won't admit they don't give a damn about their members? They don't respond, or they lie. Riisgaard lied arrogantly: "Gøtske [sic] has not been denied the opportunity to advertise. If he gives another impression, it is just to make himself interesting."

In 2016, some members of the local branch had wanted to invite me to give a lecture on psychiatric drugs, but the proposal was voted down. I replied that I found this sad and noted: "A patient association should have an open *MIND* and should not close the door when researchers have come to different conclusions about the drugs than what you hear in the marketing messages. I am also amazed that so many in the healthcare system, including patient associations, are so incredibly paternalistic and patronising and do not believe that patients are best able to assess their own situation, and are also usually able to discern sensibly when they hear opposite perceptions of things. It's actually scary to me. At the same time, we hear everywhere that the patient must be at the centre. I am sending you my book in the hope that you might still feel tempted to get an insight into how it can be that I have reached quite different conclusions about psychiatric drugs than the usual narrative."

I heard no more. The most influential organisation for psychiatric patients in Denmark is more interested in being on good terms with the psychiatrists and the drug industry than in helping their patients.

The psychiatric guild doesn't want to help patients withdraw either. I had informed Psychiatry in the Capital Region about our course explaining that I collaborated with skilled psychiatrists, psychologists, and pharmacists in several countries, and with many patients with extensive experience in withdrawal. The lecturers included a child and adolescent psychiatrist, a psychologist, and two pharmacists, one of whom was also a psychiatric survivor, all with expertise in the subject.

Three days later, Poul Videbech complained to the Patient Safety Authority: "A Peter Gøtzsche, a specialist in internal medicine, has arranged the course below for patients and others. I believe of course that he takes on a colossal responsibility that he has no knowledge at all to bear. Can doctors just do this kind of thing without having the necessary factual knowledge? Moreover, it is private entrepreneurship, which abuses the Cochrane Centre's name."[760]

Videbech's arrogance is obvious. "A Peter Gøtzsche" suggests I am unknown, but I was very well known, also by Videbech and the Authority. I wrote to Videbech that he should have cheered instead of reporting me to the Board: "Finally, there is one who does this. Although hundreds of thousands of people in Denmark are dependent on psychiatric drugs, the psychiatrists have never held such a course. They have failed their professional responsibilities. They don't even care about how best to taper off."

The Authority didn't take the complaint seriously. After four months they asked me which qualifications or experiences I had with individual withdrawal of psychosis pills, and I replied that this was not relevant because the purpose of the course was that we should learn from each other, including hearing about the patients' experiences.

I was also asked what role the Nordic Cochrane Centre had in organising the course. As there was no mention of the Centre in the announcement, I didn't reply to this question, which was irrelevant and beyond the Authority's control tasks. Later, they asked for informa-

tion I had already sent to them, and four days after we had held our course, they declared they would not take any action.

I uploaded videos of our lectures and other information.[761] We held several other meetings for the public and I gave many lectures about withdrawal, in several countries.

In 2017, psychiatrist Jan Vestergaard tried to get a two-hour symposium about benzodiazepines on the programme for the annual meeting of the Danish Psychiatric Association. Even though the meeting lasted four days, with parallel sessions, the board declared there wasn't room for the symposium. It was about dependence and withdrawal, and I was scheduled to talk about withdrawal in general, not limited to benzodiazepines.

I called the conference hotel in Nyborg, booked a room for 16 March 2018 and held a two-hour symposium for the psychiatrists in the morning, which we repeated in the afternoon, with no entrance fee.

But professor of clinical microbiology, Niels Høiby, interfered with our altruistic initiative, which was weird, as bacteria have nothing to do with drug withdrawal. He is an evil person who accused Helle, my wife, of scientific misconduct when she was preferred for a professorship rather than his own protégé. The accusation, which was groundless and ridiculous, reflected his oversized ego. Helle had presented a poster at a congress, and Høiby complained that none of his research was cited on it. But his research was irrelevant, and Helle was promoted.

Høiby was elected for a conservative political party in the region. He raised a so-called political question mentioning that I had written a book on the use of psychiatric drugs and conducted courses to get patients to reduce their use of psychiatric drugs.[762] Høiby asked if my hospital's board, the Capital Region, and the Health Council for Psychiatry, had asked the region's psychiatrists and general practitioners if they supported or distanced themselves from the activities of the Cochrane Centre's director regarding the use of psychiatric drugs.

Høiby has a habit of copying numerous people on his ravings but he did not copy our Queen or Prime Minister. The answer is as interesting as Høiby's malignant question. Psychiatry in the Capital Region declared that they had informed all their centres about the activities he mentioned; were critical of my offer; and had requested that attention be given to patients that might accept the offer. Moreover, they noted that several department heads and professors had publicly expressed their disagreement with me and my activities, e.g. at the event *The art of discontinuing a drug* organised by the Capital Region and at a public debate about psychiatric drugs organised by Psychiatry in the Capital Region: "At both events, Peter Gøtzsche himself participated."

Oh dear, can you believe it? The man "himself" showed up at our precious events and even dared ask questions! Obviously, it is unacceptable for the establishment that I try to meet the needs of the patients when the psychiatrists don't want to, even though the establishment constantly talks about putting the patient at the centre of their activities.

I advertised the symposia in our medical journal and my PhD student Anders Sørensen also lectured. Later, when we strolled around in the corridors, we learned that the young psychiatrists had been scared away from attending because their bosses would see them as heretics and might retaliate. Only seven of the 60 participants identified themselves as psychiatrists, but there were likely at least eight more who did not dare give their background when they entered the room.

Other health professionals have told me similar stories about receiving dire warnings from their superiors that if they showed up at my courses or lectures, it would not be well received at their department.

This is frightening and diagnostic for a sick specialty that behaves more like a religious cult than a scientific discipline. In science, we are keen to listen to new research results and other points of view, which make us wiser.

The symposia were a success. The most experienced psychiatrist in the room told one of his junior colleagues that I dwarfed leading psychiatrists. Which is why they didn't want their junior doctors to listen to me. It might become too difficult for themselves when they came back and asked questions. There is a video summary of our lectures.[763]

Three months after our two symposia, we held a research seminar in Copenhagen. Laura Delano from the USA presented risk-reducing taper protocols and pharmacist Bertel Rüdinger from Copenhagen, also lectured. Psychiatry had stolen 14 and 10 years, respectively, of their lives and had caused both of them to come very close to suicide.

Bertel died suddenly in 2021, only 47 years old, from a thrombosis. His psychosis pills had made him very obese, and after he came off them, he was unable to lose weight. It is likely that psychiatry killed him and took 30 years of his life.

"You too, Bertel," we said.

On 24 February 2018, Wendy Burn, president of the Royal College of Psychiatrists and David Baldwin, chair of its Psychopharmacology Committee, wrote in *The Times* that, "We know that in the vast majority of patients, any unpleasant symptoms experienced on discontinuing antidepressants have resolved within two weeks of stopping treatment."

Nine clinicians and academics, me included, wrote to Burn and Baldwin that their statement was incorrect and had misled the public on an important matter of public safety. We noted that the College's own survey of over 800 patients, *Coming off antidepressants*, found that withdrawal symptoms were experienced by 63% and that a quarter reported anxiety lasting more than 12 weeks. We added that within 48 hours of publishing their misleading statement in *The Times*, the College had removed this document from its website.

So, as soon as we sent a complaint to them, the College took down an incriminating survey that totally contradicted what they postulated. When the College refused to correct the error, we made our complaint public, and the *BBC*'s Radio 4 programme, *Today*, covered it on 3 October 2018. The College refused to participate in the programme.

Later, the Royal Society of Medicine launched a podcast series where the opening topic was depression pills and withdrawal. Psychiatrist Sir Simon Wessely, president of the Royal Society of Medicine (and recent president of the College) rejected any link between the pills and suicide and stated categorically that the pills are "not addictive."

As people wouldn't listen, we published a most damning letter in *BMJ* in May 2019.[764] When the College claimed that withdrawal effects lasted only two weeks, they referred to guidelines from the National Institute for Health and Care Excellence (NICE) stating that withdrawal symptoms were "usually mild and self-limiting over about 1 week."

We sent a freedom of information request asking for the evidence. NICE provided only two short review articles, neither of which supported the one-week claim, and they both cited numerous sources that contradicted it.

The embarrassment was now so big that the College needed to change its stance. In 2019, Public Health England published a 152-page evidence review with important recom-

mendations, including a national 24-hour helpline and withdrawal support services.[765] And NICE updated its guidelines in line with the evidence the following month.[766]

However, despite this, there was little progress. In 2023, some of us therefore published an open letter in *BMJ* saying the government has a moral duty to help those harmed by prescribed dependence forming drugs, which are used by one-quarter of the population.[767] We were frustrated that, instead of helping alleviate this enormous problem, which was very expensive for society, the government had made the situation worse.

Anders Sørensen and I decided he should mentor 30 consecutive patients who turned to us for help with withdrawal, no matter which drugs they took, and write about it because there wasn't a single such paper in the literature.

We reasoned we'd better handle this "heretic" idea with utmost care and therefore submitted a protocol to the research ethics committee. We did not want to do a randomised trial because withdrawal is a highly individual process, but we ran into a formidable roadblock. The committee responded that, although two experienced psychiatrists were involved with our project, Anders was a psychologist and there was no clear description of who was responsible for drug withdrawal, which, for reasons of patient safety, must be a psychiatrist.

An interesting remark considering that a member of the committee was a psychiatrist working at Psychiatric Centre Amager that killed two patients with psychosis pills within a short time interval because of incompetence (see Chapter 9 about forced treatment).

So, we could not see why, for reasons of patient safety, a psychiatrist must be responsible for the drug withdrawal. Moreover, it is not a legal requirement.

To assess if our study was safe for the patients, the committee asked us to do a literature review on the suicide risk for such patients. This was also an interesting remark considering that the drugs *increase* the suicide risk.

We were asked how we could ensure that only patients who tolerated drug withdrawal would be withdrawn in the study. This was a catch-22 that killed our project. No one - psychiatrists included - would be able to ensure this.

The other demands were also unreasonable. We would need to use more specific inclusion and exclusion criteria and explain which endpoints we would use and if our questionnaires were validated and made it possible to draw reliable conclusions.

Our endpoint was if the patient became medicine-free, which does not require validated questionnaires! We also needed to add a lot to the patient information. Think about it. When a research ethics committee believes it is so dangerous to help patients come off their drugs, then why were the drugs approved in the first place? Aren't they too dangerous to use? This is the logical conclusion, but healthcare is not about logic; it is about power.

After the committee had killed our project, I called a lawyer at the committee and told her that we could just withdraw the patients as planned, without calling it research. She didn't have good arguments against it, so we went ahead with this.

Many trials are still being carried out that randomise patients to a cold turkey. These trials are highly unethical. When I looked up clinicaltrials.gov and searched on depression and taper, the first trial I found, NCT02661828, compared a two-week with a one-week taper. This trial was unethical for *all* the patients. It was sponsored by Emory University, notorious for a huge corruption scandal. When whistleblowers reported to the university that millions of drug industry dollars had changed hands secretly for more than a decade, at least 15 whistleblowers were ordered psychiatric evaluations by Emory's psychiatrists – including one

of the perpetrators, Charles Nemeroff, who wrote up exams without examining the targeted doctors or gathering factual evidence, after which several of them were fired.[768]

Cochrane commits editorial misconduct and protects psychiatry and the industry

Over 100 million people worldwide are on depression pills. About 50 million will experience withdrawal reactions when they try to stop, and in 25 million, the symptoms are severe.[769] A survey of 580 people reported that in 16% of the patients, the withdrawal symptoms lasted for over three years.

It is therefore very important to know how we may best help patients come off their drugs. But when we wanted to find out, Cochrane sent us on a mission that was impossible to accomplish to protect the psychiatric guild and drug industry interests.[770]

I have described the ordeal with Cochrane in several articles.[771] I contacted psychiatrist Rachel Churchill, editor of the Cochrane depression group, at a meeting in Oxford in 2016, and she showed great interest in my proposal to do a Cochrane review on antidepressant withdrawal. I employed Anders Sørensen for the job, but when we submitted our protocol, it was not welcomed.

The Cochrane process took two years, after which they rejected our protocol. Cochrane raised their demands along the way to absurd levels with many irrelevant requirements including that we should add marketing messages about the wonders that depression pills can accomplish, according to Cochrane dogma.

Even though our project and protocol were very simple (4 pages and 15 references), it took nine months before we got any feedback. We promptly replied to the comments and submitted a revised protocol. Seven weeks later, we were told that further improvement was needed.

We submitted a third version and were told that we would hear from the group "shortly." "Shortly" became three months, and when we asked for an update, we were told we would hear from the group "by the end of the week."

The end of the week became another month. We asked again. The managing editor said she had prioritised our project and had done everything she could to speed up the process. We now suspected that her superiors had obstructed the process to wear us out so that we would withdraw the review ourselves while the group would not be seen as being unhelpful.

As over 18 months had passed, we contacted Churchill again. Seven weeks later, she replied they had had received peer reviewer feedback except one, due to be submitted later, and she attached a 30-page document with 86 points.

Four editors and three peer reviewers had provided comments, and the document took up 12,044 words, seven times more words than our protocol. Anders wrote to me that our review was quite simple and that we just wanted to help people who wished to come off their drugs but weren't allowed to do so: "What kind of world is this?"

Churchill sent the 8th review five weeks later, but her invitation from the month before to address the feedback had metamorphosed into an outright rejection: "I'm sorry that we cannot proceed with this protocol. I hope that all the peer review feedback we have sent will be helpful to you should you wish to submit elsewhere."

The 8th and final peer review was an excuse to get rid of us and it protected psychiatrists' guild interests and the drug industry. It is one of the worst reviews I have ever seen. It was 1830 words and, in contrast to the other reviews, it was anonymous. We asked for the

reviewer's identity, but this was secret. We appealed Churchill´s rejection, responded to the comments from all the reviewers and submitted a fourth version of our protocol.

Very few changes to the protocol were needed. But the 8th reviewer denied a long array of scientific facts and used strawman arguments accusing us of things we had never claimed. The main issues were these:

We were accused of "painting a picture" about avoiding using antidepressants, which did not represent the scientific consensus. Our review would not be a consensus report and it would not address drug benefits. It was about helping people come off drugs safely they didn't want to take.

We had written that, "Some patients refer to the discredited hypothesis about a chemical imbalance in their brain being the cause of their disorder and therefore also the reason for not daring to stop." The reviewer opined that we dismissed many decades of evidence relating to neurochemical changes observed in depression and wanted us to document that neurochemical theories of depression were incorrect. We responded that our review was not the place for such discussions and that the hypothesis of a lack of serotonin being the cause of depression had been discredited by many convincing studies.

As the reviewer believed in the chemical imbalance nonsense and even mentioned thyroid diseases and insulin, we explained that antidepressants cannot be compared with drugs used to treat such diseases. People with myxoedema and diabetes lack thyroid hormones and insulin, respectively, whereas people with depression do not lack serotonin.

In relation to this, the reviewer accused us of having suggested with no evidence that doctors perpetuate untruths to justify drug prescription. There is plenty of evidence for this and the patients did not invent the myth about a chemical imbalance; the psychiatrists did. However, editor Sarah Hetrick asked us to write: "People on antidepressants may believe that this is necessary because they have a belief that the difficulties they are experiencing are due to a chemical imbalance in the brain." Come on! The patients had a belief … they hadn't, before the psychiatrists gave it to them!

The 8th reviewer wanted us to "Start with a statement as to why antidepressants are considered by the scientific community to be beneficial … in treating a broad range of highly disabling and debilitating mental health problems." We responded that our review was not an advertisement for the drugs and that it was not relevant to discuss their effect in a review about stopping using them.

We were asked to explain the concept of ongoing prophylactic antidepressant treatment, "a well-accepted clinical strategy." This was outside the scope of our review, and the trials comparing maintenance therapy with withdrawal are deeply flawed because harms are introduced in the placebo group.

The reviewer claimed we conflated disease reappearance with withdrawal symptoms. In contrast to the reviewer, we didn't.

The reviewer argued that it is not an acceptable definition of dependence that an effective drug is not effective when stopped. We have never postulated anything so foolish.

The reviewer argued that most people who had taken antidepressants for extended periods could stop safely. We had documented and referenced in our protocol that this idea was totally false.

The reviewer accused us of having implicated very clearly (we had not said anything to this effect) that antidepressants are "bad medications" to be avoided, "especially as there is no mention whatsoever of the beneficial effects … I find this argument to be unscientific, and unacceptable in the context of the current evidence base."

The reviewer wanted us to remove this sentence: "the patients' condition is best described as drug dependence" arguing, with reference to the DSM-IV drug dependence criteria, that it is an unreasonable misappropriation of a term. We responded that craving larger and larger doses as a criterion for dependence is absurd, as it means that no one who smokes 20 cigarettes every day is dependent on smoking cigarettes. Nonetheless, leading psychiatrists, e.g. the chair of the Danish Psychiatric Association, Jeanett Bauer, claim that you are not dependent if you don't crave bigger doses.[772]

We ended our letter to Churchill by pointing out that the Cochrane Collaboration is about collaborating and being helpful to each other.

She ignored us. After two and a half months of waiting for a reply, we complained to Cochrane's Editor-in-Chief, Karla Soares-Weiser, a psychiatrist, about the inappropriate rejection of our protocol.

She replied we should appeal to Chris Eccleston, Senior Editor for the Mental Health and Neuroscience Network. Before we did this, we appealed again to Churchill who responded with a lie. She wrote that our protocol was finally rejected already before we received the 8th peer review and that she only forwarded the final peer review to be helpful.

Our long-held suspicion that Cochrane wasn't interested in helping patients come off their psychiatric drugs now rose to certainty.

Our appeal to Churchill was not assessed by her but by Rebecca Fortescue, the editor of the Cochrane Airways group, who upheld the rejection decision. We then appealed to Eccleston. It was a mess. Even though Fortescue had provided a list of 11 documents she received from the review group, it was not possible to see what they were about. And it was clear that she had not received our reply to the 8th peer reviewer or our revised protocol, as we had already complied with many of the issues she raised in her 2.5-page assessment.

According to Fortescue, "a reader can be left in little doubt about the review authors' stance on the relative harms and benefits of psychiatric drugs, which does not fully reflect the current international consensus and could cause alarm among review users who rely on Cochrane's impartiality." To this garbage, we politely noted that, "We are a bit surprised about this comment." Cochrane is not about consensus but about getting the science right. And assessing the harms and benefits of drugs was outside the scope of our review, and we did not offer any "stance." Other of Fortescue's criticism was also wrong.

It appeared to me that our adversaries in Cochrane had been so totally brainwashed with psychiatry's false ideas that they were unable to think clearly. Fortescue, the editors and the peer reviewers did not understand that "Types of participants" were people taking pills who wanted to come off them, even though we had pointed this out repeatedly. As the withdrawal symptoms are similar for any type of patient, disease or depression drug, it was absurd that Fortescue wanted to have a clearer description of the population, intervention and comparators, e.g. if we would include trials in migraine prophylaxis, chronic pain or urinary incontinence. Moreover, an editor asked for details about which ages, sexes, settings, diagnoses of depression, and types of antidepressants we would include, as if we were planning to do a randomised trial.

They were fools. We included *everything*, which was clear from our protocol, and our broad approach was the right one, which I had explained earlier in a *BMJ* article.[773]

One editor asked us to describe how the drugs work (they don't work) and what the differences are between them, and a reviewer asked us to explain when it was appropriate and inappropriate to use them, but we were not writing a textbook of clinical pharmacology.

Although it is true that "some people get terrible withdrawal symptoms," a reviewer wanted us to trivialise this harm by writing that, "some people get withdrawal symptoms that can negatively impact the quality of life of the patient." This must be at the top end of British understatements. We changed "terrible" to "severe."

Another absurd demand was when the Cochrane editors asked us to mention that "some antidepressants may be more effective than others," with reference to the untrustworthy 2018 network meta-analysis in *Lancet* by Cipriani and colleagues[774] (see page 24).

Eccleston summarily rejected our appeal without a single relevant comment.

We appealed to Soares-Weiser whose reply can be translated as: Guilty! In a few sentences, she claimed to have looked carefully at everything: "The comments obtained from the open peer review process consistently indicated a lack of clarity regarding the review methods proposed and, despite more than one opportunity to address this, the protocol did not show sufficient evidence that this progressed ... having considered all the information, my final decision is to uphold the rejection of the protocol."

It was not an "open peer review process." The 8th reviewer was anonymous, and we could not even check if our hangman had unacceptable conflicts of interest.

This was a tragedy that showed that Cochrane, once a highly trusted and idealistic organisation, has spiralled towards the ethical and scientific bottom and that its motto, "Trusted evidence" is a joke. It is a self-serving juggernaut whose leaders do not care about the ever-increasing workload they create for the unpaid volunteers who produce all the wealth Cochrane has.[775] As my wife has repeatedly pointed out, it is the amateurs' paradise.

In March 2023, I sent a complaint to Karla Soares-Weiser about editorial misconduct in an open letter.[776] I also complained to Cochrane's CEO, Catherine Spencer, as Soares-Weiser was conflicted in relation to my complaint. I asked some simple questions, which they refused to answer, and they did not submit my complaint to a due process. I have described the bizarre interactions I had with the Cochrane leadership in this matter elsewhere.[777] Briefly, they beat about the bush, just like the drug industry does when they have a problem.

It turned out that Cochrane has no mechanism for handling allegations of editorial misconduct in an impartial manner, something all reputable journals have. My translation of the message I got from Cochrane's CEO was: "We don't give a damn. We are beyond reproach."

I complained to Wiley, the owner of the *Cochrane Library*. They replied that, "we do not believe that the responsible handling Editors were acting in bad faith. Further, our investigation reassured us that the Editor followed editorial policy consistent with Cochrane's policy."

I also found out that, while we were being blocked from conducting our withdrawal review for Cochrane, another group had submitted a similar protocol and was given the green light to proceed, and in 2021 Cochrane published it.[778] The review was restricted to adults with depression or anxiety, which is irrational. Moreover, the review did not include trials comparing different withdrawal strategies, which we did, whereas it included many flawed studies comparing abrupt discontinuation (cold turkey) with continuation, which are of no interest.

The Cochrane review is 209 pages, the length of a full book, 23 times as long as our review of 9 pages.[779]

The Background section, 4239 words, was longer than most scientific papers and it was full of irrelevant marketing hype and misleading statements, which I noted in my complaint to Cochrane. To "prove" that the drugs worked, the authors cited the totally flawed review by Cipriani et al., which did not find a clinically relevant effect (see page 24).

The Cochrane review is unbalanced. It gives precise but misleading estimates of the benefit in the form of NNT but does not offer similar estimates for the most serious harms. This goes against the very ethos of Cochrane, which is to focus similarly on the benefits and harms of interventions. The Cochrane review mentions suicidality in many places, but it does not say that depression drugs double the suicide risk, both in children and adults.

The Cochrane review declared that continuation of antidepressant treatment reduces the risk of relapse and recurrence by 50% to 70%. This is horrible misinformation.

One of the main aims in establishing the Cochrane Collaboration in 1993 was to assist *patients* in their decision making. However, the Background section is about what *doctors* think and the review is highly paternalistic. There is no mention that many patients want to come off the drugs, which should have been the key motivation for the authors to do their review.

There is no mention in the Background section that the tapering should be hyperbolic, whereas the authors quote a 2009 NICE guideline that recommends a fast, non-hyperbolic tapering, which they don't criticise. When we started Cochrane in 1993, we were willing to criticise the authorities. The current leadership wants to please the authorities and the drug industry, which this Cochrane review demonstrates.

The abstract of the Cochrane review is 915 words, but states that "We cannot make any firm conclusions about effects and safety of the approaches studied to date."

Really? We made firm and useful conclusions in our review, which I published in a journal whose editors are not morally corrupt and have the patients' interests as their priority.[780] A median of 50% of the patients succeeded to withdraw their depression pill, and the length of taper was highly predictive for the success rate (P = 0.00001). All the studies confounded withdrawal symptoms with relapse; did not use hyperbolic tapering; withdrew the depression drug too fast in a linear fashion; and stopped it entirely when receptor occupancy was still high. The true proportion of patients on depression drugs who can stop safely must therefore be considerably higher than 50%.

Maryanne Demasi and I explained what our review meant on a website.[781] When we first published it on a preprint website, we noted an internal problem I had encountered,[782] and I published a comment on the Mad in America website.[783]

Authors' Note

Initially, the two researchers were Peter C Gøtzsche and the PhD student he had employed, psychologist Anders Sørensen. We submitted the review to a journal, which was very interested but asked for a revision. Sørensen promised to revise the manuscript but did nothing.

He did not respond to emails, never picked up the phone when he could see it was Gøtzsche who called and ignored telephone messages. After a year, Gøtzsche lost his patience and updated the literature search, added a new trial, responded to the peer review comments, and sent it all to Sørensen.

When Sørensen continued to ignore Gøtzsche, he asked the journal for advice. The editor suggested he drop Sørensen and add a new author, as there was a new trial to consider.

Gøtzsche submitted the revision with Maryanne Demasi. Then, the editor of the journal succeeded in making contact with Sørensen, who suggested his own changes, but sent them directly to the editor, without copying Gøtzsche or Demasi.

Gøtzsche added Sørensen's name to the paper again, agreeing to most suggestions and resubmitted it to the journal. Then, again, Sørensen ignored all further emails from the journal, so we were instructed to publish without him, because the rules stipulate than an author must approve the final version.

The Editor-in-Chief asked Gøtzsche to get Sørensen's signature confirming he was OK with not being an author. This was an impossible task, since Sørensen was now not responding to Gøtzsche or to the journal. We sought to ensure that Sørensen was in fact well, and we eventually established that he had been active with other projects.

The Editor-in-Chief got cold feet and asked the journal's ethical team. After this, we were told they could not publish the paper.

The paper is highly important for psychiatric patients and for those who want to help them come off their drugs, which is part of Sørensen's clinical practice.

It is unacceptable that a researcher is allowed to block publication of important research in the general interest. Since the standard is that researchers are free to publish independently if they cannot agree, we have decided to publish the review ourselves. A comment about our study and a link to it will be provided on the website of Mad in America, which is the obvious place to go to for those seeking reliable information about depression drugs.

11 Censorship, denial and lies: How the psychiatric guild protects their falsehoods

I have given numerous examples in the preceding chapters, and will give more below, of how the psychiatric guild protects its false ideas about what psychiatry can do for people with mental health issues. These examples constitute some of the most dubious censorship, concealment, and suppression practices described in the medical literature for any specialty. They involve tactics used to create a fake "consensus" around a narrative portraying mental illnesses as hereditary, caused by brain abnormalities, being dangerous or worsening if left untreated with drugs or electroshock, which are described as being safe and effective. The consensus tactics include:

- writing misleading and sometimes dangerous guidelines
- propagating falsehoods about psychiatry in scientific journals
- demanding marketing hype for drugs to be inserted in Cochrane reviews.
- ignoring blatant biases in Cochrane reviews and promoting erroneous conclusions
- indoctrinating students by writing textbooks that are full of false claims
- propagating falsehoods about psychiatry to the public in the media
- lying about opponents in the media and scientific journals
- propagating falsehoods at public meetings

Censorship tactics used to silence any information that may contradict the fake narrative include:

- preventing important research from being published in scientific journals
- preventing important letters to the editor t from being published in scientific journals
- delaying important letters to the editor for years before publication
- rejecting Cochrane reviews if the authors are not willing to praise the drugs
- censoring ads for drug withdrawal seminars from appearing in member journals
- preventing critics from speaking at meetings
- preventing critics getting critical sessions on the official scientific programme
- blocking critics from membership in professional associations
- dismissing or threatening to dismiss colleagues who use less or no medication or less or no force and restraint

Psychiatry continues to survive by lying profusely. It circles the wagons very skilfully when it is attacked, and cries "anti-psychiatry."

It is therefore no surprise that it is very difficult to get anything published in a psychiatric journal that the psychiatric guild perceives as threatening for their business. Journal editors are often on drug industry payroll and journal owners often have too close relations to the drug industry, which may withdraw their support if the journals don't further their marketing efforts.

When Bob Whitaker gave a talk in 2019 at the inaugural symposium for my Institute for Scientific Freedom, *Scientific censorship in psychiatry*, he presented two topics of great importance for public health: "Do antidepressants worsen long-term outcomes?" and "What do we know about post-SSRI sexual dysfunction?"[784] None of 13 and 14 pivotal studies,

respectively, about these subjects had been published in the top five psychiatric journals, in fact, it seemed that the top journals had never discussed these topics.

Bob has provided a list of important and large studies whose results were threatening to the psychiatric narrative and were not mentioned in any US newspapers.[785] And when newspapers do write about them, the story is usually misleading. An example is a study launched by the WHO in 1969, which showed that patients with schizophrenia fared much better in poor countries – India, Nigeria and Colombia – than in the USA and four other developed countries.[786] At five years, about 64% of the patients in the poor countries were asymptomatic and functioning well compared to only 18% in the rich countries.

Western psychiatrists dismissed the results with the argument that patients in poor countries might have milder disease. WHO therefore did another study, focusing on first-episode schizophrenia diagnosed with the same criteria in ten countries. About two-thirds were okay after two years in the poor countries versus only one third in the rich countries.

The WHO investigators tried to explain this big difference by various psychosocial and cultural factors but didn't succeed. The most obvious explanation was so threatening to Western medicine that it went unexplored. Patients and healthcare systems in poor countries couldn't afford psychosis pills, so only 16% of the patients were regularly maintained on them as compared with 61% in rich countries.

When the *New York Times* wrote about this many years later, they reported that "schizophrenics generally responded better to treatment in less developed countries." This is hugely misleading because treatments are different between poor and developed countries, and it hides that psychosis pills and harmful while suggesting they are beneficial (see Chapter 5 on psychosis).

Apart from avoiding the harmful effects of pills, there are other reasons why people with schizophrenia fared so well in poor countries.[787] The illness is often seen as the result of external forces, e.g. evil spirits, and people are much more likely to keep the sufferer in the family and to show kindness, with an expectation of full recovery, which helps patients recover and participate in social life again.

Psychiatry professor Giovanni Fava, whom I met at a meeting in Denmark where we both lectured, found it so difficult to get results his peers didn't like published, that he founded his own journal, *Psychotherapy and Psychosomatics*. Another Italian psychiatrist, Giovanni Fioriti, who has published five of my books in Italian and once invited me to dinner in his home, launched a free access journal with no author fee, *Clinical Neuropsychiatry*.

The censorship in the media is also huge. When my first psychiatry book came out in Swedish in 2016, the publisher invited me to lecture in Stockholm. I was interviewed by journalists from the two major newspapers who were highly interested, but nothing was published. Inger Atterstam from *Svenska Dagbladet* didn't reply to my emails asking why, whereas Amina Manzoor from *Dagens Nyheter* said her editor thought it would be too dangerous to explain to Swedish readers that depression pills are harmful and can cause suicide, because knowing this would somehow itself be dangerous!

There was a crack in the Swedish censorship, however, as a third newspaper, *Aftonbladet*, allowed me to publish an article that filled the whole back page where I explained that psychiatric drugs do more harm than good.[788]

The *Finnish Medical Journal* (*Suomen Lääkärilehti*) also exhibited censorship in 2016. I had published a paper on Mad in America that explained that our two systematic reviews from the same year showed that antidepressants increase the risk of suicide and violence at all ages, and not only in children and adolescents; that psychotherapy decreases the

suicide risk; and that the clinical benefit of antidepressants is doubtful.[789] I concluded that these drugs shouldn't be used and that people with depression should get psychotherapy and psychosocial support.

I submitted a Finnish translation of my paper, which was accepted. A month later, however, the Editor-in-Chief, Pekka Nykänen, rejected it without a valid reason.[790] Nykänen, a business journalist, violated the guidelines of the Committee on Publication Ethics (COPE): "Editors should not reverse decisions to accept submissions unless serious problems are identified with the submission." I appealed but to no avail.

Next, I appealed to the journal's owner, the Finnish Medical Association, and argued that editorial misconduct can be equally serious as scientific misconduct and should not be tolerated. I received a short mail from its CEO, Heikki Pälve, who did not consider my complaints and the lack of response by Nykänen to my highly relevant questions. Instead, Pälve replied that he respected "the editorial freedom of the journal." This was bullshit. It is not freedom to violate internationally accepted guidelines; it is editorial misconduct.

In 2017, Bob published an article with the biblical title, *Thou shall not criticize our drugs*,[791] about a horrendously flawed review of the long-term effects of neuroleptics. The authors claimed that there is no good evidence that antipsychotics worsen long-term outcomes, while also claiming that there is good evidence supporting their long-term use. They cherry-picked studies and dismissed studies that told of long-term harm to such an extent that their review may serve as a case study of institutional corruption. Two groups of psychiatrists submitted highly relevant letters criticising the review to the journal, *American Journal of Psychiatry* - owned by the American Psychiatric Association, an organisation solidly corrupted by industry money. The editor rejected both letters.

One of the review's preposterous claims was that "It is possible that antipsychotics may have deleterious effects on normal brain but protective effects in the presence of schizophrenia-related neuropathology." The critics noted that, "This explanation ignores the similarity of the brain changes induced in animals to those seen in patients following long-term antipsychotics ... Furthermore, it invokes the extraordinary assumption that there exists a 'schizophrenia-related neuropathology' which responds to D2 dopamine blockade in the opposite manner to that of the brains of the remainder of humankind."

When my book about organised crime in the drug industry was published in Spanish in 2014, I was interviewed by a journalist from the leading newspaper in Barcelona, *La Vanguardia*. The interview was planned to fill the back page, which readers find more attractive than the front page. It never appeared, even though the journalist was very enthusiastic about it. I found out that there were unhealthy financial relationships between the newspaper and the drug industry.

It is also very difficult to get critical documentaries on national TV. If you succeed, the best parts have been removed to avoid getting too many complaints from the psychiatric guild, the drug industry, or the Minister. I know that this is the case because I have appeared in many documentaries and have talked with many frustrated filmmakers about it. Even after they removed the most critical parts to suit producers, there were voiceovers telling the audience, for example, that, "many people are being helped by antidepressants." If so, where are these people?

It can also be difficult to publish highly relevant books about the horrors of psychiatry. Silje Marie Strandberg from Norway was bullied at school from age 12 and was admitted to a psychiatric ward aged 16. She was diagnosed with moderate depression and was put on

fluoxetine (Prozac), and the dose was doubled after three weeks, which, as I have explained earlier, is insane, as it doesn't increase the effect, only the harms, including the risk of death.

Silje started cutting herself, became aggressive, heard an inner voice, and got suicidal thoughts. She was prescribed chlorprothixene, a psychosis pill, and three days later, she saw a man with a black robe and hood who said she was about to die and ordered her to drown herself in a river. She fought and cried when he spoke to her, said she didn't want to die, but he told her she didn't deserve to live. She went into the river while crying she wouldn't do it, but thankfully came out again. These delusions were drug induced and stopped when she came off the drugs.

Psychiatry stole ten years of Silje's life, with serious self-harm and many suicide attempts. She was put in restraints 195 times, was diagnosed with schizoaffective disorder, got electro-shocks and was secluded.

After seven years of torment, she met a caregiver who saw the girl behind the diagnosis and took care of her. This human effort is why Silje is alive and healthy today.

In 2016, Silje and her filmmaker, Inger Lene Stordrange, came to Copenhagen to film me for a documentary about her life.[792] The documentary is freely available. It is very good, informative and deeply moving.

Silje had previously had an agreement with a book publisher, Psyk Opp, about what both of them perceived was one of psychiatry's success stories. I told her she had been seriously harmed by psychiatry, which she accepted, but when her psychiatric "career" was no longer a success story but a scandal, it was not possible to publish her book. She was not allowed to tell the world that the drugs she was on had made her terribly ill, to the brink of suicide.

Silje was medicated by 95 different doctors and received 21 different drugs during her psychiatric "career:" nine psychosis pills, five depression pills, four sedatives/ hypnotics, two antiepileptics, and lithium.

Another story about censorship involved Danish Lundbeck that sells several pills against depression and psychosis. A very moving Norwegian film, *Cause of death: unknown*, had its world premiere at the Copenhagen documentary film festival, CPH:DOC, the largest in the world, in 2017.[793] It is about the filmmaker's sister who was killed by her psychiatrist. He overdosed her with olanzapine (Zyprexa) after first having turned her into a zombie. He was so shockingly ignorant that he didn't even know that olanzapine can cause sudden death.

I appear in the film and the filmmaker, Anniken Hoel, asked the organisers to put me on the discussion panel. My name was the only one in the announcement: *Medicine or manipulation? Film and debate about the psychiatric drug industry with Peter Gøtzsche*.

Seven days before the film was to be screened, I was kicked off the panel under the pretence that the organisers couldn't find a psychiatrist willing to debate with me. This was not the real reason. It turned out that the Lundbeck Foundation, whose objective is to support Lundbeck's business activities, had provided a major grant to the festival.

CPH:DOC never contacted me about it, even though I could have provided several names of psychiatrists willing to debate with me.

The panel included Nikolai Brun, newly employed chief of staff at the Danish Drug Agency after a long career in the drug industry that ended just before the film festival, and psychiatrist Maj Vinberg whose benefactors included Lundbeck and AstraZeneca. She had published utter nonsense about depression being hereditary and observable on brain scans and was very fond of psychiatric drugs, which she seemed to know very little about.

The panel debate was embarrassing. After 25 boring minutes, excepting the filmmaker's contributions, only five minutes remained. A former patient interrupted Brun, who had talked endlessly, shouting: "Questions!" Many people in the audience had lost loved ones, killed by psychiatric drugs, and they had become increasingly angry because the panellists only discussed amongst themselves and didn't want to involve the audience. There was time for only three questions.

A woman asked why antipsychotics had not been taken off the market, as they killed people. Brun replied he wasn't an expert on psychiatric drugs and embarked on another endless talk, about cancer drugs.

I then shouted: "Questions from the audience!" A young man said he had tried to come off his depression pills several times without success and without any help from doctors. A member of my staff later helped him withdraw.

The last question was posed by Anahi Testa Pedersen whose film about me and her own experiences as a psychiatric patient had its world premiere in the same cinema seven months later.[794] She asked why I was taken off the panel since I could have made a good contribution and even appeared in the film. A festival spokesperson replied they had asked "a lot of people," but that no one wanted to debate with me. Anahi interrupted and named a psychiatrist who would have liked to come. The spokesperson changed tactics and now said that since the film was critical, there was no need for me; they needed someone to debate the film's messages. This was unadulterated bullshit.

In the middle of the endless fake excuses, someone in the audience shouted: "There is no debate!" The spokesperson replied that they would invite me for "tomorrow's debate," which I refused, as they had kicked me off from the world premiere of the film.

Seconds before the time ran out, I stood up and shouted (because I doubted, I would get the microphone): "I am actually here. I debate with psychiatrists all over the world, yet I am not allowed to do this in my hometown." There was a big laughter and applause, but the audience was angry. It was deeply insulting to them to show a film about a young woman killed by an overdose of Zyprexa without allowing any of those who had lost a family member in the same way to say anything. It was a brutal dismissal and a total prostration before the power of Lundbeck.

Anahi wrote about the scandal in a magazine for journalists.[795] She noted that before I was removed, the organisers had announced there would be a sharp focus on the overconsumption of psychiatric drugs and on whether drugs were the best treatment of psychiatric disorders. After my removal, the focus was on the relationships between doctors, patients, and industry, which couldn't be a reason for removing me, as this was the subject of my award-winning book from 2013.[796]

CPH:DOC writes on its website: "We have many years of experience with sponsorship agreements that cater to both individual enterprises and to the festival. All collaborations are created in close dialogue with these individual businesses and are based on common visions, challenges and opportunities."

In response to Anahi's article, Vinberg wrote in the magazine it was a pity that a debate supposed to be about improving the future treatment of people suffering from a severe mental disorder, schizophrenia, ended in a rather indifferent debate about individuals (me). Her misleading statement was contradicted by her evasive responses during the panel debate itself.

Another instance of censorship involved Danish public TV. Independent documentary filmmaker Janus Bang and his team had followed me for four years and wanted me to have a central role in their documentaries about how awful and deadly psychiatry is. Janus ran into a huge roadblock and needed to compromise extensively to get anything out on TV. Despite this, he broadcast three interesting programmes in 2019, *The dilemma of psychiatry*,[797] which were shocking. For example, he followed a young man who the psychiatrists came close to killing with their drugs.

But the public debate he so much wanted in order to have major reforms introduced was totally absent. Psychiatry's firm grip on society prevented this from happening.

I wasn't allowed to appear at all unless a voiceover would say I am controversial. Janus refused to accept this, and I agreed with his decision. "Controversial" is a derogatory term that ensures the viewers will disregard everything you say, thinking you cannot be trusted.

Drug exports are Denmark's biggest source of income, and there were embarrassing, totally false voiceovers paying lip service to Lundbeck and the psychiatrists, e.g. that psychiatric drugs had revolutionised the treatment; that it may be necessary to use a potentially dangerous mixture of psychotropic drugs to treat mental illness; and that there is no doubt that antidepressants work.[798]

Journalists have told me that the reason Danish public TV doesn't dare challenge psychiatry or Lundbeck's commercial interests is due to the pushback around two programmes in April 2013.

I was interviewed in one of them, *Denmark on pills*, by comedian and journalist Anders Stjernholm. The introduction to the programme mentioned a patient with massive side effects of antidepressants; another, who lost his sex drive; and a third who was diagnosed with ADHD by a psychiatrist who had never met him.[799]

The overall message was that happy pills are dangerous and prescribed too often. But the psychiatric empire hit back immediately. In an open letter to the board of the TV station,[800] 92 specialists said they found it "deeply problematic that a public service channel has seen it as its task to combat the use of a medication that is of crucial importance to the health of many people." They also noted that the programmes were "based on individual statements and opinions from so-called experts, the most used of whom is a specialist in internal medicine [me] and therefore has no experience with treatment of psychiatric patients … The broadcasts are a clear disavowal of the thousands of doctors who treat patients with antidepressants on a daily basis. They must appear completely untrustworthy when, for decades now, they have been prescribing medicine which, according to DR's 'experts,' is ineffective at best, dangerous at worst."

In reply,[801] channel chief Michael Thouber noted that around 450,000 Danes use antidepressants; that the chairman of the general practitioners, Henrik Dibbern, had sounded the alarm about this "hideously high number;" that psychiatrist Poul Videbech had said in a TV interview that there were so few that had a depression requiring treatment that it can be assumed that between 350,000 and 400,000 Danes used antidepressants without it being the right treatment; that the OECD had pointed out that Denmark is in a dismal second place in the consumption of antidepressant medication in a comparison between 19 European countries; that, at the end of 2012, both doctors, psychiatrists and the Minister of Health commented publicly that they found this alarming; and that some doctors are apparently too quick to prescribe the medicine without providing proper information about side effects and other forms of treatment.

Child and adolescent psychiatrists complained that the programmes could harm children with ADHD and noted that some parents had stopped a well-functioning treatment, which they claimed "can lead to a worsening of the symptoms and cause major problems with playing and socialising, participating in and benefiting from school education and causing risky behaviour."[802] I was called a populist professor even though what I had said was correct, in contrast to their own views of what the drugs can accomplish, which are wrong (see Chapter 4 on ADHD).

In a magazine for journalists, Videbech called the programmes a scare campaign that can cost people their lives and added that he knew several examples of suicide after friends and family advised the patient to drop antidepressant medication.[803] He compared this with advising patients with diabetes to drop their insulin, even though he, at the same time, fiercely denied that he believed in the lie about the chemical imbalance (see page 13). As noted earlier, Videbech's view is that antidepressants protect children against suicide even though the opposite is true.

One of the reasons why Videbech makes many errors is that he is unable to interpret the scientific literature correctly.[804] He has claimed, for example, that citalopram can heal the destruction of brain tissue that depression causes,[805] with reference to a totally unreliable study where 32 depressed people got the drug for 8 weeks.[806]

Videbech was angry that he had been left out of the programmes and complained about it on Facebook and to Danish TV: "It became clear … that they didn't want real information about these problems - something that the viewers could really benefit from - but instead had picked in advance some views they sought to confirm."

Videbech described how the journalist repeatedly asked him questions according to his own agenda, which was that "antidepressants do not work;" "if they work, they cause suicide;" and "when you stop them, they cause horrible abstinence symptoms."

Videbech is regarded as a top figure in depression, a national icon, and he is often interviewed. This gives him oracle status, which he uses to influence the public agenda and to shape what people think about depression and depression pills.

I had documented for Stjernholm - who made the programmes, *Denmark on pills* - that depression pills don't work; that they increase the risk of suicide; and that patients can get horrible withdrawal symptoms when they try to stop them.

There were many commentaries to Videbech's article in the magazine. One noted that I was correct that the media were uncritical and that many people had tried to warn against psychiatric drugs but had been silenced or fired. This had of course also happened to me, which I wrote a book about[807] that I updated[808] because Janus and I are currently making a documentary film about the affair, *The honest professor and the fall of the Cochrane empire*, which we are resourcing through crowd funding.[809]

Another commentator found it incredibly manipulative that Videbech claimed that people had committed suicide after stopping their drug and had compared this with diabetics needing insulin.

One noted that there were virtually no tapering programmes in psychiatry and that it was solely up to the doctor's opinion what to do, which resulted in lifelong medication for many people.

One mentioned she was a member of a large support group helping people harmed by psychiatric drugs, and that every time they tried to open a debate on this topic, they were accused of not thinking about those who benefit from the medicines and were told that their information could have fatal consequences.

One wondered why we heard nothing from psychiatry about the suicides and suicide attempts that the drugs cause: "Because it gets dismissed as non-occurring. Nevertheless, it was on the list of side effects in the package insert of the medication I received. AND I felt the impulse on my own body. BUT I was told it was my depression that was the trigger for suicidal thoughts and plans. The strange thing about that was that the impulse came shortly after I started on the drug ... But the conclusion from the doctor and others involved was that my dose should be increased, which I luckily declined and decided to taper off the drug on my own. That people change their personality totally - become aggressive and hot-headed, paranoid, etc. - is also dismissed."

Only four days after Stjernholm's documentaries, also in 2013, journalist Poul Erik Heilbuth showed a fabulous documentary, *The dark shadow of the pill* on TV.[810] He documented in detail how Eli Lilly, GlaxoSmithKline and Pfizer concealed that their depression pills cause some people to kill themselves or commit murder, or cause completely normal and peaceful people to suddenly start a spree of violent robberies in shops and gas stations they were unable to explain afterwards and were mystified about. The pills changed their personality totally. Heilbuth told the stories of several people who had killed themselves or others.

The background material (no longer available) noted that Professor Tim Kendall - the head of the government body that advises all English doctors - called the theory of the chemical imbalance rubbish and nonsense. Professor Bruno Müller-Oerlinghausen - the leader of the German doctors' Medicines Commission for 10 years - called the theory insane. Both professors said the theory was a pure marketing strategy for drug companies. Heilbuth furthermore noted that the official Danish health website (written by Danish professors of psychiatry) propagated the chemical imbalance nonsense.

Heilbuth had whistleblower Blair Hamrick in his film, a US salesman who said that their marketing mantra to sell GlaxoSmithKline's drug paroxetine (Paxil or Seroxat) was that it is the happy, horny and skinny drug. They told doctors it will make you happier, you will lose weight, it will make you stop smoking, it will increase your libido (it does the opposite) – and that everybody should be on this drug.

The reactions to one of the most truthful films about psychiatric drugs ever produced were fierce. An editorial in the newspaper *Politiken* condemned the documentary in a very hostile fashion, and Heilbuth responded.[811] *Politiken* called his film "immensely manipulative," "sensationalism," "merely seeking to confirm or verify the thesis that the programme had devised as its premise," and they called Müller-Oerlinghausen a "muddled thinker."

It looked to me as if *Politiken*'s editorial was written by Lundbeck. The "muddled thinker" gave lectures all over the world, including at a symposium half a year earlier organised by the Danish University Antidepressant Group. He was very clear and well-argued throughout the film, and what he said was absolutely correct. David Healy was also one of the film's main sources.

In 2016, Videbech attacked Danish TV again, in his usual arrogant fashion, after its documentary, *The healthy patients*. He accused the programme of stigmatising people with depression and not doing proper journalistic research,[812] which wasn't correct and was rejected by the programme director.[813]

The media's false narrative about psychiatry

With few exceptions, the media behave like the drug industry's useful idiots, propagating uncritically virtually any falsehood psychiatry can think of.

After decades of disappointment about the way the media depict psychiatric issues, I finally had enough and wrote an article discussing the reasons behind the false narrative.[814]

First, many journalists learn at journalism school that they should be balanced. But "balanced" reporting often leaves the public confused. When both sides are given similar prominence, people might conclude that the jury is still out even when the case is settled. "Balanced" reporting makes people dumber than they should be.

Second, many journalists take psychiatric drugs and think they work, or they have friends or relatives that take drugs, work for a drug company, or are psychiatrists. This can cause journalists to react violently and go directly against the scientific evidence and the authorities' warnings. I have experienced countless vitriolic attacks on this basis. A journalist triumphed in a tabloid newspaper with the headline: *I take happy pills, otherwise I would be dead!*[815] She called me a life-threatening person, delusional, not in complete balance with myself, one who might need to see a psychiatrist, and I should be ashamed of myself and be deprived of my professor title: "My wish is that someone can stop the mad professor."

Third, negative stories rarely get published, not even when the journalist is eager to publish them. This is because many media are corrupt. Editors don't want to lose advertising income and they often have their own financial conflicts of interest in relation to the drug industry.

Fourth, editors know they could make hell for themselves if they publish critical articles or documentaries about drug harms. They might face a storm of protests from key opinion leaders and questions might be raised in parliament, often via people secretly financed by the drug industry. The editors fear offending consensus and buy the false argument that any bad publicity about psychotropic drugs can cost lives, so the science is edited out in favour of personal anecdotes, which are more convincing for readers than hard-core science.

Fifth, even though journalists often check if statements from politicians are true, they are surprisingly uncritical towards statements from powerful people in healthcare. They don't realise that most leading psychiatrists have serious misconceptions about their specialty, and that many lie bluntly about the facts.

Sixth, there can be substantial pressures from patients. Some are celebrities or journalists hosting TV programmes, and they may be readily offended if their illness is not recognised or if their drug use is questioned. Many journalists will feel obliged to accommodate such people and to present their stories, often supported by their psychiatrists. They can also be afraid of being seen as uncompassionate and don't have a ready answer to what an alternative would be. They could remedy this by interviewing critics of psychiatry, e.g. from the survivor movements, but often fail to do so.

When the media – rarely – do tell of a serious harm of a psychiatric drug, they follow a standard script, which is that they must also praise the drug. This results in meaningless and false marketing statements such as "despite their side effects, the drugs are worth taking," or "many people have been helped by them."

A recent and typical example of media corruption was a 2023 report from *BBC Scotland* about Dylan Stallan, who had never expressed suicidal thoughts before he started treatment with sertraline for anxiety but committed suicide at age 18.[816]

BBC misled the public saying that the effectiveness of antidepressants on under-18s is not fully known and that there is "some" clinical trial evidence to "suggest" the drugs increase the risk of suicide in young people. Not so. *All* the evidence, the placebo-controlled trials, *prove* that the risk of suicide is increased.

Child and adolescent professor of psychiatry Bernadka Dubicka told the *BBC* about an increase in suicidal thinking and self-harm in the first few weeks, and Anton Ferrie from the *BBC* wrote that among the more severe side-effects were "suicidal thoughts."

This is horribly misleading. Suicidal thinking and self-harm are relative mild events, but the drugs double the number of suicides (see chapter on depression). Moreover, the suicide risk is not limited to the first few weeks of therapy. People can kill themselves at any time, particularly after a dose change.

Family doctor and sexual medicine expert, Dr Ben Davis, said that some people's lives had been saved by antidepressants. But these drugs don't save lives; they take lives. They kill people to such an extent that antidepressants may be the major killer among all drugs.[817]

I wonder why the media never mention that psychotherapy halves the risk of suicide.[818] The obvious reason is that psychotherapists don't corrupt the media, the psychiatrists or the politicians with their money, which is what the drug industry does.

The *BBC* spoke to over 100 people and all of them reported side effects of some kind. Why are these drugs then used? The sexual medicine expert said that one in two people will have some difficulty with sex, and *BBC* described a man who lost his sex drive within 24 hours and is now asexual, with numbness in his genitals, which still persisted 12 months after he stopped taking antidepressants. He has Post-SSRI Sexual Dysfunction (PSSD) and is one of more than 1,000 people who are part of the PSSD Network that raise awareness of the condition, which is not currently recognised by the National Health Service.

The bottom of journalism was reached when former First Lady, Rosalynn Carter established the US Carter Center's Guide for Mental Health Journalism, the first of its kind. The Carter Center educates journalists to write flawed articles, uncritically repeating the misleading narratives created by the drug industry and psychiatrists, and to never question psychiatric diagnoses.[819]

Some of the "facts" journalists are urged to include are: "Substance use disorders are diseases of the brain," and the guide explains that "Although science has not found a specific cause for many mental health conditions, a complex interplay of genetic, neurobiological, behavioral, and environmental factors often contribute to these conditions." This mumbo jumbo is misleading. We know that people's living conditions are more important than anything else.

It is difficult to see much hope for America. When the Carter Center tells journalists to ignore patients and listen only to psychiatrists, it is like telling Chinese journalists that if they want to know what it is like to live under a dictatorship, they should not ask the people but the Chinese leaders.

The ten myths in psychiatry that are harmful for the patients

In January 2014, I published an article in the newspaper *Politiken*, *Psychiatry gone astray*,[820] which also appeared in English,[821] where I described ten myths in psychiatry that are harmful for the patients:

Myth 1: Your disease is caused by a chemical imbalance in the brain.
Myth 2: It's no problem to stop treatment with antidepressants.
Myth 3: Psychotropic drugs for mental illness are like insulin for diabetes.
Myth 4: Psychotropic drugs reduce the number of chronically ill patients.
Myth 5: Happy pills do not cause suicide in children and adolescents.
Myth 6: Happy pills have no side effects.
Myth 7: Happy pills are not addictive.
Myth 8: The prevalence of depression has increased a lot.
Myth 9: The main problem is not overtreatment, but undertreatment.
Myth 10: Antipsychotics prevent brain damage.

I ended my article this way:

"Psychotropic drugs can be useful sometimes for some patients, particularly in short-term use, in acute situations. But after my studies in this area, I have arrived at a very uncomfortable conclusion: Our citizens would be far better off if we removed all the psychotropic drugs from the market, as doctors are unable to handle them. It is inescapable that their availability causes more harm than good. The doctors cannot handle the paradox that drugs that can be useful in short-term treatment are very harmful when used for years and create those diseases they were meant to alleviate and even worse diseases. In the coming years, psychiatry should therefore do everything it can to treat as little as possible, in as short time as possible, or not at all, with psychotropic drugs."

My article caused an outcry, spearheaded by the drug industry and their paid allies among doctors and the media. But it also led to the biggest debate in Denmark ever about psychiatric drugs. For more than a month, there wasn't a single day without discussion of these issues on radio, TV, in newspapers, or at psychiatric departments.

This was surprising to me. Half a year earlier, I wrote something similar in my book about organised crime in the drug industry, in the chapter, *Pushing children into suicide with happy pills*, but this did not result in any debate about psychiatric drugs:[822]

"How come we have allowed drug companies to lie so much, commit habitual crime and kill hundreds of thousands of patients, and yet we do nothing? Why don't we put those responsible in jail? Why are many people still against allowing citizens to get access to all the raw data from all clinical trials and why are they against scrapping the whole system and only allow publicly employed academics to test drugs in patients, independently of the drug industry?"

In my book, I wrote the exact same sentence about citizens being far better off if we removed all the psychotropic drugs from the market. But this time, people reacted. The same day my article appeared, Thomas Middelboe, chairman of the Danish Psychiatric Association, lied bluntly in the same newspaper, on its website:[823] *Antidepressant drugs protect against suicide*.

I got the whole Danish establishment on my back, including the Director of the Board of Health, Else Smith,[824] (who, however, thanked me the same day on the radio for having raised an important debate),[825] the Danish Cancer Society and the umbrella Organisation of the Danish Medical Societies. The chairman of the Association of General Practitioners, Henrik Dibbern, supported me: "Peter is not a great diplomat. But it is also necessary to shout loudly in this area. Even when he provided heavy documentation, he was often ignored."[826] The Minister of Health, Astrid Krag, called my article vulgar, stupid and dangerous,[827] and the biggest patient organisation opined that I derailed the debate.[828] Yet, the

only thing I had done was to tell people the truth,[829] but this is not tolerated when the subject is psychiatry.

A PhD in psychopharmacology, Jesper Tabias Andreasen, wrote that I was anti-psychiatry and scared the patients away from taking their drugs. His headline was satiricial, that we could remove all drugs - not only psychiatric drugs - and avoid all side effects.[830]

Like Andreasen, the press also ran amok and misrepresented what I had written to such a degree that I needed to state that I had never argued that all psychiatric drugs should be removed from the market.[831]

Kristian Villesen, editor of the newspaper *Information*, was one of the very few journalists who understood the issues.[832] He wrote that my article had provoked general practitioners and psychiatrists so much that they deliberately failed to read the text properly, which is why I was "exhibited as an advocate that no one should be given psychotropic drugs. No sane person thinks that - not even Gøtzsche. His sharp rhetoric was obviously an attempt to provoke the doctors to think about how much medicine they prescribe. The point was that the doctors should get better - not that the medicine should be taken off the market. People with a specialist medical training behind them should be able to see through this - and of course they can."

Editor of *Politiken*, Christoffer Emil Bruun, also saw through all the smoke and mirrors.[833] Under the headline, *Is there a normal Dane present?*, he wrote that the explosion in drug usage, which the Minister of Health, Astrid Krag, had said called on the attention of Parliament in *Politiken* in 2012, did not get the attention of the whole country before I wrote about it. He criticised the psychiatrists for not having addressed what I wrote, e.g. about the influence of the drug industry and that the diagnoses are not reliable. Instead, the psychiatrists had claimed that there are more patients who need antidepressants and are not on them than patients who are on them but don't need them.

In his newsletter to the Danish Psychiatric Association, Middelboe repeated the falsehood that I wanted to take all the psychiatric drugs off the market, which he said was life-threatening.[834]

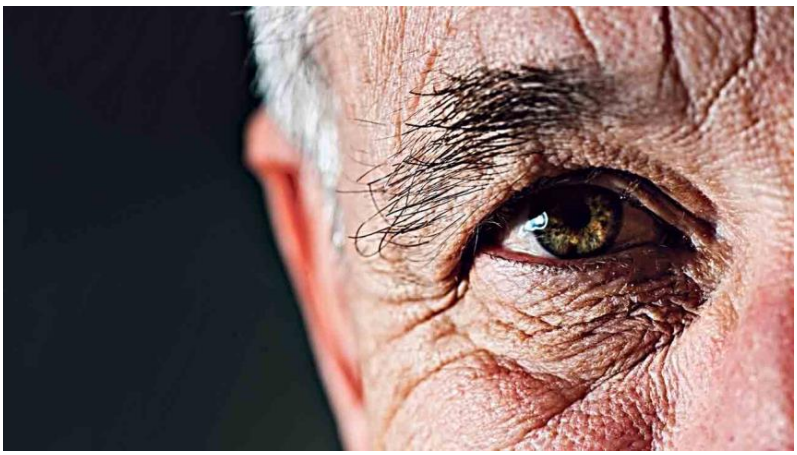
The absolute low point was delivered by Lars Kessing, Merete Nordentoft and Thomas Middelboe who, on behalf of all professors in psychiatry and in child and adolescent psychiatry, and the Danish Psychiatric Association, declared - without mentioning my name, just like one was not supposed to mention the evil Lord Voldemort's name in Harry Potter - that:[835]

- there is no overtreatment of depression
- antidepressants work and prevent new episodes
- antidepressants reduce the risk of suicide in children
- antidepressants do not lead to dependence
- antipsychotics work and reduce the risk of death
- Open Dialogue does not work (for psychoses)
- exercise has no effect on psychiatric disorders.

Middelboe said they wrote the article because there are so many myths and erroneous information about psychiatric drugs in Denmark. Which they then propagated themselves, as all their claims were wrong. They didn't see the irony of course, when they called me extreme and unreliable.

I told *Politiken* that I needed to write another article because they had made so many errors. I responded to the untruthful remarks in the article, *Leading psychiatrists have still gone astray*.[836]

An editorial in an industry funded magazine said that "It is not possible not to admire the courage, Peter Gøtzsche displays. The Cochrane boss is as popular in healthcare as Voldemort is in Harry Potter."[837] My opponents often use my name in the titles of their articles, which is a kind of harassment. This also happened this time. The magazine published a 7-page article, *Peter, the wolf: Gøtzsche versus Gøtzsche,* which looked like an attempt at character assassination.[838] Two full pages were a photo of one of my eyes:



Child and adolescent psychiatrist Lisbeth Kortegaard provided a devastating criticism of the article.[839] She called it mean and spin of the worst kind to compare me with a predator and noted that she had observed how I was celebrated at the Selling Sickness meeting in Washington DC and the Preventing Overdiagnosis meeting in Dartmouth in 2013.

Two months later, Lisbeth wondered why the psychiatrists continued their witch hunt after me, noting that they should think about why one out of every 500 Danes considered my article important.[840]

In February 2014, 16 Danish professors of psychiatry responded to my article.[841] Among other things, they repeated the lie that treatment with neuroleptics increases longevity, compared with no treatment.

Cochrane censorship, protection of psychiatry and industry, and my expulsion

In March 2014, the Danish Psychiatric Association's attempt to character assassinate me almost succeeded. They wrote to the two Cochrane groups dealing with schizophrenia and depression, complaining about my article about psychiatry's ten harmful myths.[842] They mentioned that I had been criticised by the Minister of Health, the director of the Board of Health, the director of the Danish Patients Association, the president of the Cancer Society, the president of the Danish Psychiatric Association and the president of the Organisation of Danish Medical Societies.

They ended their letter by asking: "How do you, with the specific knowledge you have on antipsychotics and antidepressants, respectively, evaluate Peter Gøtzsche's statements as presented in his article. We would be very pleased if you would take up the task of making such an evaluation."

It wasn't the task of Cochrane to evaluate what I had written. But its CEO, deputy CEO and two other people in Cochrane's leadership replied. They wrote: "Cochrane is treating very seriously the points you raise concerning comments made by Professor Gøtzsche on the use of psychotropic medication. I want to state [the inadvertent use of "I" shows that Cochrane's CEO, journalist Mark Wilson, was the author of the letter] explicitly that these are not the views of The Cochrane Collaboration on this issue and we do not endorse them." The letter noted I was speaking on my own behalf, which was correct, and as "part of the promotional work" I conducted surrounding publication of my book about organised crime, which was not correct.

I wasn't consulted on their response and didn't even know what was taking place. I was in a jungle in Panama with my wife when this happened, surrounded by birds, tarantulas, caimans, monkeys, butterflies and sloths, with little contact to the outside world.

I had no chance of defending myself. The news that my own organisation had denounced me ran amok in the Danish media, and the psychiatrists celebrated their kill by reading aloud Cochrane's letter at the Danish Psychiatric Association's annual meeting.

My newspaper article starts thus: "I have researched antidepressants for several years and I have long wondered why leading Danish psychiatrists, including several professors, base their practice on a number of erroneous myths, which are unfounded. These myths are harmful to the patients, particularly since Danish psychiatry is extremely top-down controlled. Many psychiatrists are well aware that the myths don't hold and have told me so, but they don't dare deviate from the official positions because of career concerns. Being a specialist in internal medicine, I don't risk ruining my career by incurring the professors' wrath and I shall try here to come to the rescue of the many conscientious but oppressed psychiatrists and patients by listing the worst myths and explain why they are harmful."

In my article, I referred to my book about organised crime.[843] Wilson stated that, "The views contained in this book are also not the views of Cochrane." This showed that Cochrane

was beholden to the drug industry. The comment was ridiculous. How could Cochrane's CEO have other views than mine on the drug industry's well-documented organised crimes, which he knew very little about? Furthermore, the psychiatrists had not referred to my book, so why did he mention it? Obviously because he wanted to get rid of me, which he succeeded in doing four years later.

Another sentence in Wilson's letter was also not a response to an issue the psychiatrists had raised: "We will be asking Professor Gøtzsche to share with Cochrane colleagues any unpublished data that is not yet publicly available, so that it can be incorporated objectively into new or existing Cochrane Systematic Reviews as appropriate; and then be seen and evaluated by you [the Danish psychiatrists] and other specialists in the field."

Wilson totally undermined my position as an independent and well-respected scientist. I was not surprised that a journalist at *Politiken* interpreted this as meaning that I had now come under Cochrane censorship and wouldn't be allowed to publish anything unless it had been approved by Cochrane headquarters.[844]

Wilson's letter was a threat to what I had built up over 30 years, including my centre, which received government funding. The Minister of Health had declared publicly in January that my person and the centre wasn't the same thing,[845] which I and my senior researchers interpreted as meaning that I could be fired. Very weird indeed, as I had simply pointed out what is well documented and what many others had pointed out before me.

When I came back from the jungle to participate in Cochrane meetings in Panama City, one of the four who signed the letter apologised to me. But Wilson just stared at me with his cold, evil eyes.

Journalist Ole Toft from *Altinget*, the newspaper that broke the story, misrepresented Wilson's letter.[846] The subheading stated that I did not have support "for a number of controversial statements about the drug industry and the use of psychiatric medicines," which other journalists uncritically repeated, disappointingly even in the *Journal of the Danish Medical Association*,[847] and which people interpreted as an acquittal of the drugs industry's crimes and a negative verdict about my book. Toft even fabulated that, "the organisation doesn't agree either with the views Peter Gøtzsche describes in his book where he compares the business model of the drug companies with criminal organisations." This was free fantasy, and I documented in my book that Pfizer had been convicted of organised crime and that other companies did business the same way. It was scary to see the extent to which journalists distort their stories when they smell blood.

After this experience I felt like the senator in ancient Rome who said that people would not succeed stabbing him in the back, as he had so many scars already that the knife would not get through.

Some people in Cochrane's leadership got cold feet and sent a letter to *Altinget*, explaining there had been "misunderstandings."[848] It was too late. The damage was done and not a single journalist admitted they had misrepresented Wilson's letter, even though some of what they had written was demonstrably untrue.

I published various rebuttals, including an article with a similar title as one of H. C. Andersen's famous stories, *The Cochrane feather that became five hens*,[849] which is about how rumours become established truths when they are repeated often enough.

Outside the power circles, my paper about the ten myths was much appreciated.[850] It was translated into English, Spanish, Norwegian and Finnish, and many articles followed, some written by psychiatrists who agreed with me. People in Norway and Sweden thanked me for having started a debate that was impossible to have in their country, and I received

hundreds of emails from patients that confirmed with their own stories that what I had written was true.

One patient wrote that he was admitted with a first-episode mania, and although he asked not to be treated with drugs, he was forced to take olanzapine. He tried to behave well, fearing that he might otherwise not be released. At discharge, a psychiatrist declared him cured and insisted that he should continue with the drug. He didn't dare tell her that he had spat out most of the pills in the washbasin but asked, for the sake of appearances, for how long he should take the drug. For the rest of his life, she replied, because he had a chronic disease, with a great risk of relapse, and he should not be afraid of the drugs' harms. The reason why he didn't take the drug was that he had read my article. He has been well ever since without drugs.

Psychiatry continued as usual, but many people told me that my books and articles saved lives. They gave the patients the courage to stop their drugs against their doctor's advice.

Ten months after my article, *BMJ* published a paper with views very similar to mine,[851] but the authors did not become scapegoats for psychiatry's failure to deliver.

It didn't last long before Cochrane came after me again, and once again they ignored the science and protected psychiatry's guild interests and false beliefs, and the drug industry. In May 2015, I gave a talk at the Maudsley debate in London and explained, also in an article in *BMJ*, why long-term use of psychiatric drugs causes more harm than good.[852] I had informed my Cochrane colleagues in advance of my article as a courtesy, but my kindness was not returned. The same day my article appeared, Cochrane's Editor-in-Chief, David Tovey, and the three editors in charge of the three Cochrane mental health groups, attacked my scientific credibility on *BMJ's* website:[853]

"In summary, we are concerned that the picture painted by Professor Gøtzsche may be a partial one, and that the extreme recommendations he makes based on his interpretation of the published research are inappropriate, and insufficiently justified by the scientific literature presented, to guide decision making in practice or health policy."

My colleagues stabbed me in the back instead of asking me about the issues they were concerned about, which were all thoroughly documented in my book that appeared four months later.[854] Several editors of other Cochrane groups told me they were dismayed that the four editors had denigrated my research and my professional prestige by appealing to authority. A news channel got it right: "Unable to counter Gøtzsche's arguments in any rational or scientific manner, organized psychiatry, and, alas, members of the Cochrane Collaboration itself, have disgraced themselves with suspiciously speedy and mendacious denigrations of his work."[855]

The Cochrane editors' rapid response appeared in *BMJ* even before the Maudsley debate was over, and professor of psychiatry Allan Young used it his final remarks during the debate, which was recorded,[856] but the chair did not allow me to respond. Young claimed that my *BMJ* paper had been rebutted by the Cochrane editors, which was not the case, and could not be the case, as my position was solidly based on good scientific evidence while the Cochrane editors' rapid response was evidence-free and opinion based, which I explained in my reply.[857] I also alerted the *BMJ* editors to the fact that Young - who defended psychiatric drugs in the debate - had not declared his conflicts of interest in relation to the drug industry. Medical journals normally publish a correction alerting readers to the fact that an author had failed to declare his conflicts of interest, but this didn't happen. They protected Young by inserting the missing conflicts into the text of the paper instead.

My criticism of psychiatric drugs was the reason why Wilson considered me to be in bad standing, as they say in gangster circles. Three years after the Maudsley debate, he ensured I was expelled from Cochrane's Governing Board, to which I had been elected with the most votes of all 11 candidates, and expelled also from the Cochrane Collaboration. He even got me fired from my job as director of the Nordic Cochrane Centre.[858]

Cochrane's actions against me were widely condemned, e.g. in *Science*, *Nature*, *Lancet* and *BMJ*.[859] My first book about Cochrane's show trial against me was reviewed by child and adolescent psychiatrist Sami Timimi:[860]

"This book chronicles how an upside-down world is created when marketing triumphs over science; where the actual target of a years-long campaign of harassment gets labelled the guilty party ... The book stands as a detailed study in how organisations become corrupted … the most important institution left that could be trusted when it came to medical science, has disappeared … Indeed it was because Professor Gøtzsche was prepared to call out the lowering of scientific standards in Cochrane that the hierarchy felt compelled to plot his demise.

Gøtzsche … created many of the methodological tools used by Cochrane reviews and has never shied away from letting the data speak for itself, however unpopular the findings might be … Gøtzsche was, and is, an inspiration to those of us who want medical practice to be as objective, free from bias, and safe as possible; but a threat to those who put commercial matters, marketisation, and image as their primary concern.

Gøtzsche's brilliance and his fearless approach earned him many enemies. He is one of Denmark's best-known researchers … His work on psychiatric drugs showing how poor they all are at delivering better lives for those who take them, at the same time as causing enormous harms to millions, has earned him the ire of the psychiatric establishment at large, including some Cochrane groups ...

Instead of congratulating Gøtzsche for ensuring the integrity of the science produced by Cochrane, they began a challenge to this truth seeker for being 'off message.' This book carefully recounts this dark period in medical science where a once trusted institution carried out one of the worst show trials ever conducted in academia. The CEO and his collaborators went about their task in a manner that mirrors how the drug industry operates ...

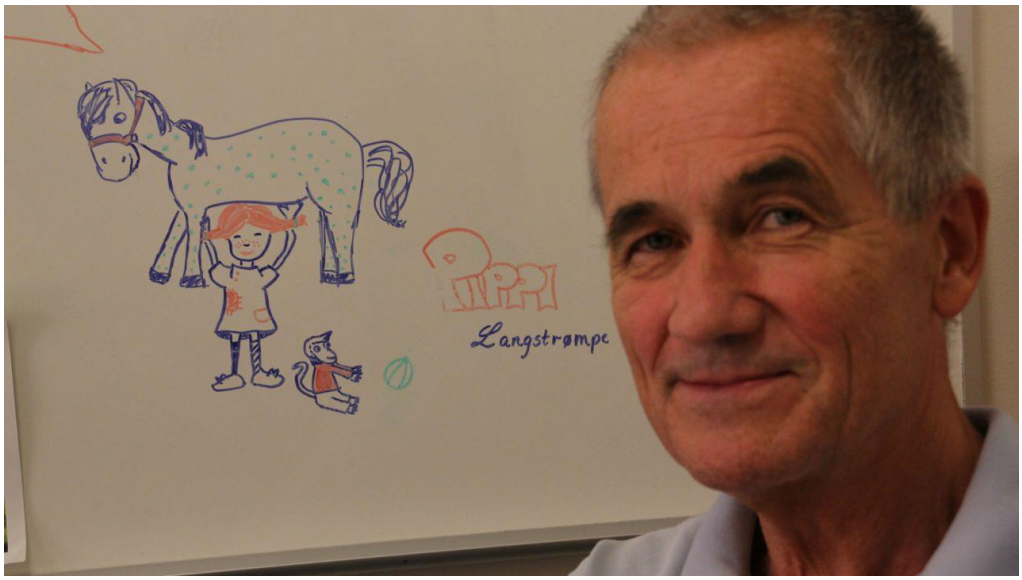
After his expulsion from Cochrane … four members of the board walked out in protest. Leading medical scientists from all over the world expressed their solidarity with Gøtzsche and outrage at what Cochrane had done. They universally praised Gøtzsche as a tireless advocate for research excellence, a fearless critic of scientific misconduct, and a powerful opponent of the corruption of research by industry interests, and criticised the unsupportable actions of Cochrane. History will recount this as the death of Cochrane rather than the whistleblower."

Deadly psychiatry and organised denial

I published my first psychiatry book, *Deadly psychiatry and organised denial*, on 31 August 2015.[861] When it came out, there were two articles in *Politiken*,[862] and I was interviewed by both Danish TV stations. Two weeks later, it was the second most sold non-fiction book in Denmark.

The book has appeared in nine languages and was praised by psychologists, other people from the caring professions, lay people, patients, and journalists.[863] When I was interviewed

by a science site, they included a drawing my 10-year-old daughter Pernille had made about Pippi Longstocking carrying a horse. The idea was that, when she could to that, I could also change science, which was the title of the article.[864]



Readers of the newspaper *Berlingske* nominated me for "Dane of the Year" in 2015 where I ended in top ten. I was invited to the award ceremony where I met with the Prime Minister, Lars Løkke Rasmussen, who said he appreciated my work with drugs. Eske Willerslev, our world-famous DNA researcher, who has documented many historic migrations of people including that the American Indians came from Siberia and that the Danes came from Caucasus, also appreciated what I did. He offered to give a lecture at my centre, which he subsequently did.

Under the headline, *I call a spade a spade*, a journalist explained why I had been nominated:[865]

"In particular, he has drawn attention to the harmful treatment methods of psychiatry with his book 'Deadly psychiatry and organised denial.' He has thus made a very significant contribution to public education and to a debate, which has been much needed ... Professor Peter C. Gøtzsche is fighting a tireless fight for medicines to be used correctly ... Like no one else, he has started a vital debate about overmedication."

My work for the patients was so much appreciated that I became Protector of the Danish Hearing Voices Network the following year.

A patient very aptly called his article *Psychiatry: Doctors without borders*.[866] Another person wrote that I would go down in history for daring to show that the Emperor was naked, and that, in the best of all worlds, a book like mine would lead to big and comprehensive changes; yet another hoped for a more humane care with less dogmatic medicine but doubted it would happen.[867]

Psychologist Svend Brinkmann noted that if I was correct, psychiatry needed to be radically changed, without delay.[868]

Doctor of philosophy Ivar Mysterud wrote that my book is probably the most important one that is critical of psychiatry.[869] He liked my direct style and noted that if we want to revolutionise psychiatry, we cannot treat people with verbal silk gloves. He found that when

traditional psychiatrists had tried to dismiss my criticism as erroneous, I had presented their arguments and crushed them through incisive analyses.

Psychologist Hans Peder From wrote that one of his clients was so medicated that she slept all the time, was unable to take care of her child, and just wanted to get a disability pension.[870] He convinced her to taper off her medication and she became a competent mother with a full-time job.

His wife was also overmedicated and couldn't do anything. It was difficult for him to persuade her to come off the drugs because her psychiatrist was very much against it. When his wife asked for some literature on recovery, it turned out that the psychiatrist had never heard of this. And when they investigated if it made sense to try to get a new psychiatrist, they were told that she was the most modern and progressive of the staff.

The tapering was extremely hard, with violent nightmares, and he had recurring discussions with his wife. Was the psychiatrist right that she would always be sick? Or was he right that she could do much better?

His wife can still become psychotic in stressful or emotionally charged situations, but this was also the case when she was drugged, and she is doing much better now. As he says, in biological psychiatry, there is no ambition to make people healthy. They aim for well-medicated or well-regulated patients, which is just a nice way of saying you've created another chronic patient.

A client told him about her brother: His psychiatrist had said he was schizophrenic and had to take medicine for the rest of his life. This was the last conversation she had with her brother before he killed himself. From says that people with mental illness can fully or partially recover, but not when the treatment system robs them of all hope.

As expected, my book was forcefully attacked by the establishment. Allan Flyvbjerg, Dean at Aarhus University, opined that it is downright harmful for psychiatric patients when a high-profile researcher like me comes up with “biased and rigid attacks on the usage of drugs in psychiatry.”[871] In his view, the road to a better psychiatry was clear: New and more targeted psychiatric drugs, and he praised the Lundbeck Foundation for a big grant exceeding 240 million Danish kroner.

In my reply to Flyvbjerg’s article, I noted that, given he was an endocrinologist, he should have been concerned that many patients treated with neuroleptics become obese and develop diabetes and cardiovascular diseases.[872]

Top psychiatrists denigrated my book and routinely lied about what I had written. Torsten Bjørn Jacobsen, chairman of the Danish Psychiatric Association, published a pathetic and untruthful review in our medical journal.[873] He claimed that I believed that suicide and psychoses would not occur if it were not for the abuse in psychiatry; opined that I had no expertise in psychiatry; that I quoted selectively; and that my style was implacable.[874]

Well, if you want to achieve changes in psychiatry, you need to be clear about what you say. And not being a psychiatrist (the “you are not one of us” argument) is not a valid argument. You don't have to be a banker to have a qualified opinion about the 2009 financial crisis. And when I document how ineffective and harmful psychiatric treatments are, I use research done by psychiatrists and supplement it with my own research.

Poul Videbech was behind a headline in *Politiken* saying, “I have had patients hospitalised who stopped taking medication and attempted suicide because of the debate that was going on."[875] He called it unethical not to treat severe depression with antidepressants because it increases the risk of suicide not to treat and the risk that the depression becomes chronic

and impossible to cure. The truth is the opposite. Depression pills double suicides and make depression a chronic condition.[876] (see also page 153)

Raben Rosenberg called it an unethical, monomaniac, anti-psychiatry crusade against psychiatric patients and opined that I was unable to interpret the scientific literature.[877]

Pernille Lundqvist claimed on Facebook that my articles and books were devoid of evidence, which she opined was why the debates were derailed.

In an article called, *Peter Gøtzsche as today's crusader*, Mads A Meldgaard Madsen claimed that drugs are an absolute prerequisite for conversations, care, professional help and recovery, in contrast to the evidence.[878]

Psychiatrist Henrik Day Poulsen claimed I was the leader of an anti-psychiatry movement and that drugs prevent suicide and violence and increase the quality of life substantially. He found it dangerous to have an academic discussion and ignore clinical experience![879]

John Hagel Mikkelsen claimed I was totally ignorant about psychiatric disorders and their treatment and that his 25-year clinical experience told him that seriously ill patients with psychosis or depression come back to life with the help of antipsychotics or antidepressants.[880]

A Finnish psychiatrist called his book review *Anti-psychiatry 2.0* in the *Finnish Medical Journal.*[881]

Swedish professor of psychiatry Mikael Landén wrote an extremely mendacious book review in the *Swedish Medical Journal* entitled, *Gøtzsche's book is the opposite of scientific honesty*.[882] Landén's claims are free fantasy, and the reader comments to his review are interesting.[883]

I have never said that:

- psychiatric drugs have no positive effects at all
- they "regularly" drive people to murder and suicide
- it is doubtful whether mental illness exists
- voice hallucinations are normal
- if only the patients were freed from the psychiatric web, mental illness would disappear
- it is a myth that Alzheimer's is a brain disease

Landén's lies were brutal: "His only explanation for the fact that psychiatric drugs have been shown to have effects in studies, and are used, is corruption and conspiracies." It is also a lie that I do not provide references when I conclude that some psychiatrists are corrupt. I give many references and mention names, for example Anders Forsman from Sweden and Joseph Biederman, with references to the corruption.

Landén claimed that I did not document that about half of the psychiatrists lie to their patients. But I write on page 8 in the book: "One sign that psychiatry is in deep crisis is that more than half the patients believe their mental disorder is caused by a chemical imbalance in the brain. They have this misperception from their doctors, which means that more than half the psychiatrists lie to their patients."

Landén claimed that I do not have compassion for those who suffer from mental illness and that as an anti-psychiatric knight I am not interested in the suffering and disability that mental illness leads to in everyday life for many fellow human beings.

Landén was happy to discuss, but only with "people who have at least rudimentary knowledge of psychiatry and some small compassion for those affected."

Landén said he learned nothing from reading my book. I consider this impossible.

Several psychiatrists felt Landén had written an excellent book review and agreed that I was "anti-psychiatry," whereas child and adolescent psychiatrist Sven Román wrote that if only a fraction of what I had written was correct, psychiatry was a gigantic scandal.

This was a defining moment when Swedish psychiatry revealed itself.

A few psychiatrists did not delude themselves. Jens R Bang noted that his colleagues had not been able to counter my arguments with reference to concrete research and he called for an academic debate: *Evidence-based psychiatric treatment, what else?*[884]

Retired psychiatrist Frits Schjøtt wrote that my book was not encouraging reading, but if we hoped to wrest the poor people with psychological problems out of biological psychiatry and the mafia claws of the pharmaceutical industry, there was no other way.[885] He wished he had known what my book had taught him 40 years ago, which would have been good for his patients and for his self-esteem in his retirement, but "we needed an independent researcher in the new millennium to open our eyes."

Stuart Shipko from California wrote on Mad in America[886] that my book "brings up an important and complex issue. How do psychiatrists get up in the morning and damage people all day long while pretending to help them? The book is elegantly referenced – and I encourage everyone who practices thoughtful psychiatry to read it, because you need to be much better educated to practice high-quality mental health than you do to act as a dispensing machine. Gøtzsche is absolutely right; on all levels psychiatrists are in denial about the damage that they are doing to patients ...

Even taking cognitive dissonance into consideration, psychiatrists can surely see what is in front of their eyes. I remember years ago when Risperdal - the new miracle antipsychotic - came on the market. The first patient I gave it to gained about 60 pounds in just six weeks ... I have never prescribed Ritalin or other stimulants for children … How can a doctor fail to notice stunted growth that makes a 12-year-old look like a 9-year-old? How can a doctor fail to notice all the tics and twitches? …

Patients complained all the time about sexual dysfunction continuing long after stopping SSRIs. Pharmacists know about this problem. Patients are well aware of this problem.

I recall an attorney who was having mild depression related to financial difficulties. He was given samples of Paxil for a month or two, until I ran out of samples. He was unable to afford the prescription. Three days later he attempted suicide. One patient of mine in therapy for panic attacks with no depression was convinced by her daughter to get an SSRI from her family doctor. She hung herself from a stairway in her house a few days later ...

When I see patients for second opinions about what is usually an unnecessary cocktail of drugs for a diagnosis of bipolar disorder, despite the fact that the patient never had a manic or hypomanic episode, I often ask a Socratic question. I ask them to visualize their psychopharmacologist, and ask themselves whether they would buy a used car from this person. Most patients laugh – and say that they would not. So why trust your life to this person?"

No hope for biological psychiatry: It must be stopped

In 2005, Steven Sharfstein, president of the American Psychiatric Association, wrote that "Pharmaceutical companies have developed and brought to market medications that have transformed the lives of millions of psychiatric patients."[887] Sure, but not for the better. He even claimed, contrary to the evidence, that "Big Pharma has helped reduce stigma associated with psychiatric treatment and with psychiatrists."

In 2011, prominent psychiatrists wrote:[888] "Persistent, untreated depression produces a type of neurodegenerative disorder, associated with synaptic changes ... Similar to poor control of blood sugar in diabetics, poor control of symptoms in Major Depression is associated with worse long-term outcome and greater overall disability ... antidepressants prevent relapses ... 53% of the placebo patients relapsed, whereas only 27% of drug-treated patients relapsed ... After the FDA issued a black warning against antidepressants … there has been a concomitant increase in actual suicide ... There have been concerns regarding whether certain antidepressants may cause suicides. We now know this is a myth largely fuelled by the media ... Newer studies of children do not confirm an increase in suicidal ideation ... Naturalistic studies show that the incidence of the suicide rate tends to go down as the incidence of antidepressant treatment goes up."

All of this is harmful nonsense, and it is strange that Stefan Leucht, who has published much good research and is an editor in the Cochrane Schizophrenia Group, co-authored this. It shows that even the best psychiatrists may suffer from collective delusions and denial.

A 2012 newspaper article written by four leading Danish psychiatrists called *Behind the myths about antipsychotics* was similarly tragic.[889] They wrote that most patients suffering from schizophrenia have disturbances in the dopamine system; that the genes are by far the most important cause (about 70–80%); that large international registry studies show that patients who are not treated with psychosis drugs are at higher risk of dying prematurely than those who are treated; that numerous studies have documented that the risk of new psychotic episodes and a more severe course of the disease is increased if patients stop taking the drugs; that there were no indications that polypharmacy with psychosis drugs increased mortality in their own study; and that large register-based studies in Denmark and Finland show that concomitant treatment with several drugs does not increase mortality.

Yet again, all the claims made by prominent psychiatrists were totally wrong.

In 2020, the Danish Psychiatric Association published a 21-page leaflet, *Make psychiatry healthy*. The Association wanted more money and more of the same, which would only make psychiatry sicker than it already is.[890] The leaflet noted that the number of patients had increased from 110,000 to 151,000 in just eight years. There was nothing about overdiagnosis or that one of the main reasons why seriously ill patients live substantially shorter lives than others is the treatment the psychiatrists provide to them, often against their will. They claimed that 74% of the forensic psychiatric patients received inadequate psychiatric treatment in the period before they committed the crime and that crimes can be reduced by better treatment. No drugs can reduce crimes unless you make zombies out of the patients with neuroleptics. Psychiatric drugs *increase* the risk of violence.[891]

Regarding a tragic case in which a mentally ill man killed his psychiatrist with a knife, the chairman of the Danish Psychiatry Foundation, Torsten Bjørn Jacobsen, stated in a newspaper that when people with mental illness commit crimes, including murder, it is in the vast majority of cases because of insufficient treatment. I explained that this was not correct.[892]

Psychiatric textbook authors are preoccupied with telling the students that psychiatric disorders are hereditary. Obviously, this gives the specialty prestige. It makes it look more scientific to claim that the disorders are in the genes and can be seen in a brain scan or in brain chemistry. There was a lot of detail about genetic research in the textbooks but none of it was correct.[893] The many twin studies have been debunked, but even if they were true, it would have no clinical consequences, as we cannot change our genes.

When I was young, the narrative was that 10% of children who had a parent with schizophrenia would become schizophrenic, and people were understandably worried they might be next. Even today, websites claim that the risk is 10–15%,[894] and the misinformation can be much worse. A 2022 article in *Nature* by the Schizophrenia Working Group of the Psychiatric Genomics Consortium mentioned, as the first sentence in their abstract, that "Schizophrenia has a heritability of 60–80%, much of which is attributable to common risk alleles."[895] Yet, in another article by this group, which is very difficult to comprehend, the genes appeared to explain only about 2% of the risk that a person will be diagnosed with schizophrenia.[896] Thus, 98% of the risk must be because of something else, most notably trauma, where there is a clear dose-response relationship.[897]

Yet, many billions of dollars have been wasted by the NIMH on finding genes predisposing to psychiatric diseases and on finding their biological causes. Even though the many gene studies have not come up with anything,[898] the mad hunt for the Loch Ness monster continues. Since 1996, the NIMH directors, Steven Hyman and Thomas Insel, have transferred funds from clinical research to basic research projects, especially genetic studies, so that very few clinical trials are now carried out.[899] The current director, Joshua A Gordon, claims that investing heavily in basic research will ultimately lead to better treatments. We know that this is not true.

It is harmful to tell the patients that their disorder is hereditary, as it takes away their hope of becoming normal again. If instead the psychiatrists focused on the environment the patients live in and the traumas they have experienced, there would be hope of recovery, as the environment can be changed, and traumas can be treated with psychotherapy.

In contrast to the psychiatric leaders, the public is convinced that madness is caused more by bad things happening than by genetics or chemical imbalances in the brain.[900] The spending of enormous amounts of money - largely by drug companies - to teach the public to think like biologically oriented psychiatrists has led to more discrimination, more drugs, more harms, more deaths, more people on disability pension, and greater costs for society.

A major risk factor for becoming depressed is living a depressing life you feel you cannot escape from. However, there was very little information in the textbooks that environmental factors, traumas, other psychosocial factors, poverty, discrimination, and other poor life conditions, can be important for mental health. When I examined claims that psychiatric disorders are caused by brain abnormalities, I consistently found that the research in support of the claims was unreliable.[901]

Sadly, one of the most important studies I have come across in my whole career is virtually unknown. Studies of people that have not been randomised but have chosen themselves what to do, e.g. to exercise or not, are called observational studies. Such people differ in many other respects, and it is therefore common to adjust for baseline differences with statistical methods. However, statistician Jon Deeks showed that it is not possible to adjust reliably for baseline differences. Ingeniously, he used raw data from two randomised multicentre trials as the basis for observational studies that could have been carried out. He found that the more baseline variables we include in a logistic regression, the further we are likely to get from the truth.[902] He also found that comparisons may sometimes be *more* biased when the groups appear comparable than when they do not. He warned that no empirical studies have ever shown that adjustment, on average, reduces bias.

Many false claims in psychiatry are derived from observational studies, which is why it is important to know about Deek's study.

Another general problem with the textbooks was that the psychiatrists protected their guild interests and their industry benefactors by not mentioning that the drugs they use can cause the disorders they try to treat, other disorders, or serious harms. For example, they avoided commenting on the well-known studies that found that psychosis pills shrink the brain in a dose-related fashion and that the disease cannot explain these changes.[903] Some authors claimed that untreated psychosis increases the loss of brain volume; that it is likely that psychosis pills can offer some protection; and that prolonged untreated depression may cause brain atrophy. There is no reliable research in support of these fantasies.

Strangely, ADHD - one of the most controversial diagnoses in medicine - was claimed to be one of the psychiatric disorders with the strongest evidence for a neurobiological etiology, with aberrations on brain scans (which isn't correct, see the chapter on ADHD). Even anxiety disorders were claimed to be visible on brain scans, which normalised on successful treatment. This is a tautology like: It will rain tomorrow, or it will not rain. If the brain scan was not normalised, the treatment was not effective.

The fact is that brain scan studies are extremely unreliable. You can get any result you want. One researcher found that there were 6,912 unique ways to analyse the data - and scientific misconduct is common.[904] When the Editor-in-Chief of *Molecular Brain* requested to see the raw data in 41 of the 180 manuscripts he had handled, only one survived; 21 manuscripts were withdrawn by the authors, and he rejected a further 19 "because of insufficient raw data."[905]

Child and adolescent psychiatrist Sami Timimi explains in his book *Insane medicine* that psychiatry ignores much of the genuine science and instead supports and perpetuates concepts and treatments that have little scientific support.[906] He calls this scientism. Psychiatry likes to talk in the language of science and treats this as more important than the actual science, which is exactly what practitioners of alternative medicine do.

In Sami's debates with fellow psychiatrists about the evidence, three defenses are common. The first is the use of anecdote - such and such a patient got better with such and such a treatment, therefore, this treatment works. The second is an appeal about taking a "balanced" perspective. But we get our ideas on what is balanced from what is culturally dominant, not from what science tells us. The third is that when molecular genetics has consistently failed to produce anything about diagnoses being related to specific genes, we are told that the area is "complex." According to philosopher Harry Franklin this is bullshit.[907]

Humans do not like uncertainty, which is in our genes, as indecision decreases our chance of survival. It is a curious trait of human psychology that once you have made up your mind, even when you were in serious doubt, you will vigorously defend your position when someone proves that the other option was the correct one.[908] People who spread misinformation may therefore spread their false ideas even more forcefully and uncompromisingly when confronted with irrefutable evidence that they are wrong. Psychiatrists also need to stick to their false ideas about diagnosis and treatment to preserve the way they practice. As Upton Sinclair said, "It is difficult to get a man to understand something, when his salary depends on his not understanding it."

I have told students[909] that if they ask questions to their teachers based on my Critical Psychiatry Textbook,[910] they might be fobbed off with replies like, "Gøtzsche? Never heard about him" (even though they know who I am), "Don't waste your time on him," "Is Professor Gøtzsche a psychiatrist? Has he ever managed psychiatric patients? How can he judge what we do?" Or they will say I am an anti-psychiatrist, which is silly. We have never heard of an anti-cardiologist, and you are not an anti-mechanic because you criticise poor

repair work on your car. Students should not accept such replies but always ask for the evidence.

I wrote my Critical Psychiatry Textbook hoping I might influence students of psychiatry before it is too late, and they have accepted the false narrative.

The many erroneous and misleading statements I found cannot be explained by the advent of new, important knowledge, as the publication dates for the textbooks are recent, from 2016 to 2021.

The textbook authors were heavily influenced by the drug industry. For example, they never spoke of harms of drugs, only "side effects," which is a euphemism. All textbooks used industry jargon and talked about first-, second-, and even third-generation pills; some neuroleptics were called atypicals and some were called modern, suggesting you are outlandish if you prefer older drugs. As the drugs *within* these arbitrary classes are widely different in their effects, it is meaningless to divide them this way. There wasn't a single remark in the textbooks that off-patent drugs should be preferred because they are vastly cheaper and not any worse than patented drugs. It was as if health economics was something you could only find on the Moon or in excavations.

It is a bit amusing that psychiatrists say that psychiatric patients have no insight into their disease when they themselves have no insight into what their specialty does to people. I have experienced that very few psychiatrists understand the basics in clinical research. They therefore cannot assess what they read critically but do what their leaders tell them to do, which is what the industry wants them to do.

One reason why psychiatry is so harmful is that almost all placebo-controlled trials of psychiatric drugs are flawed, and most Cochrane reviews and other systematic reviews of such trials are also flawed, as they are not sufficiently critical.[911] Furthermore, when depression trials and other trials have a statistically nonsignificant primary outcome, there is often spin on the results, which gives the readers the impression that the drugs were effective nonetheless.[912]

Another reason is that the outcomes are assessed on meaningless rating scales people trust at face value instead of asking for outcomes that matter such as returning to a normal life. To claim that a reduction of symptoms of emotional pain on a rating scale is proof of efficacy is like claiming that aspirin can heal a broken leg because it reduces physical pain.

The American Psychiatric Association's disease manual, DSM-5, states that major depression is present when the patient exhibits at least 5 of 9 symptoms that "cause clinically significant distress or impairment in social, occupational, or other important areas of functioning." Given how the disorder is defined, it makes no sense that drug trials don't use such outcomes. Over a thousand placebo-controlled trials have been carried out, but I have not seen any that reported if depressed patients came back to a normal productive life. The same applies to other psychoactive drugs.

A score on a rating scale cannot tell us if the patient is well. The popular Hamilton depression scale contains items that are not specific to depression, e.g. sleeping difficulties, anxiety, agitation, and somatic complaints. These symptoms are likely to respond to the sedative effects of many substances, including alcohol, opioids, psychosis pills and benzodiazepines, but we do not call them antidepressants. Using this scale, even stimulants like cocaine, ecstasy, amphetamine, and other ADHD drugs could be called antidepressants. Almost everything could.[913]

Yet another reason why drug effects have been much exaggerated is that, in most trials, the patients were already on a drug like the one being tested. When they are randomised to placebo, some of them develop withdrawal symptoms that often mimic disease symptoms. Thus, the new drug outperforms placebo in patients who have been harmed.

The lack of blinding is also important. Because of the conspicuous side effects of psychiatric drugs, some patients, and their doctors, know who is on drug and who is on placebo, and the small differences recorded on a rating scale can be explained by this bias.[914]

Because of these biases, drug companies can show that their drugs "work" for virtually everything, and investigators may report positive effects that only exist in their imagination.

This occurred in a famous trial of 344 newly admitted patients with schizophrenia funded by the NIMH in 1964,[915] which is still highly cited as evidence that psychosis pills are effective. The investigators reported, without offering any numerical data, that phenothiazines reduced apathy and made movements less retarded, the exact opposite of what these drugs do to people, which the psychiatrists had admitted a decade earlier.[916] The investigators felt the drugs should no longer be called tranquillisers - which is what they are - but antischizophrenic drugs.

The real reason that psychosis pills were hailed as a great advance was because they kept the patients docile and quiet, which was very popular with the staff in psychiatric wards.[917] It was a huge conflict of interest that the same staff evaluated whether the patients had improved or not, which clouds psychiatric practice and research even today.

Drug agencies should not have approved psychiatric drugs based on flawed evidence. But they don't care. We have documented that their guidelines for psychiatric drug trials are deficient.[918] The recommended designs are for trials of short duration; with restricted trial populations; allowing previous exposure to the drug; and often recommending rating scale efficacy outcomes.

To find out for how long patients should be advised to continue taking their drugs, so-called maintenance studies, also called withdrawal studies, have been carried out. They are highly misleading because of cold turkey effects. A meta-analysis of 65 placebo-controlled trials found that only three patients needed to be treated with psychosis pills to prevent one relapse after one year, but the apparent benefit of continued treatment with psychosis pills decreased over time and was close to zero after three years.[919]

When follow-up is longer, it turns out that discontinuing psychosis pills is best. Nonetheless, two psychiatric textbooks noted that some or most patients with schizophrenia will need lifelong treatment.[920] It is really bad medicine to keep the patients on their toxic drugs for years or lifelong based on the false belief that this improves their prognosis. There is only one appropriately planned and conducted long-term maintenance trial, from Holland.[921] Patients who had their dose decreased or discontinued fared much better than those who continued taking drugs: 40% versus 18% ($P = 0.02$) had recovered from their first episode of schizophrenia after seven years of follow-up.

A recent withdrawal trial from Hong Kong was totally misleading.[922] There was nothing about their tapering scheme, but an earlier publication stated that they didn't taper at all; all the placebo patients were exposed to a cold turkey. The investigators tried to explain away what they found in a most astounding way. They suggested there might be a time window between year two and three where it was important that the patient did not relapse. The plausibility of the existence of such a time window is zero, as it is highly variable when or if a patient relapses. After ten years, 69% of those who continued taking their drug were

employed versus 71% in the cold turkey group, which is remarkable considering that the psychiatrists had harmed the latter group.

Please also think about this: Why would drugs that have no clinically relevant effects when used for acute psychosis (see Chapter 5 about psychosis) suddenly have dramatic effects on relapse when they are withdrawn? It makes no sense.

At best, psychiatric drugs can provide some relief in acute situations. Long-term, they are very harmful. All of them impair higher brain functions, which is what makes us human – our abilities to think, feel, function, remember, love, have empathy, and care for ourselves and others. Many drugs can cause permanent brain damage, loss of sexual function, and horrible abstinence symptoms when patients try to get off them.[923]

When we looked at permanent brain damage in animals, we included 33 studies in mice, rats, hamsters, cats and monkeys. We were unable to publish our results, even in medical journals that publish systematic reviews of animal research. We were told the studies were of poor quality. This is true, but our review is helpful for researchers planning to do similar studies, and we therefore published it on my website.[924]

Some of the drugs that have been most widely used are also some of the most harmful ones, e.g. olanzapine, fluoxetine, paroxetine, and alprazolam.

This is because most leading psychiatrists are corrupt.[925] Psychiatrists collect more money from drug makers than doctors in any other specialty; those who take the most tend to prescribe psychosis drugs to children most often; and they are also "educated" with industry's hospitality more often than any other specialty.[926]

The corruption is colossal. A 2007 paper surveying US department chairs of medicine and psychiatry reported that 67% of them had received "discretionary funds" from industry within the last year,[927] which is money they can use as they please. This is likely an under-estimate, as the survey was not anonymous. I would call them "discrete funds," as they are often not declared, contrary to the rules.[928]

A Danish psychiatrist described vividly "A so-called whore trip" in our medical journal.[929] When Lundbeck launched escitalopram in 2002, most Danish psychiatrists were invited to an enjoyable meeting in Paris with "expensive lecturers - of course from Lundbeck's own 'stable' - luxurious hotel and gourmet food ... Under influence? … a doctor doesn't get influenced, right?"

Thomas Insel and the NIMH: A total betrayal of public trust

The director of the US National Institute for Mental Health from 2002 to 2015 was Thomas Insel, called "America's psychiatrist." In 2022, he published the book, *Healing: our path from mental illness to mental health*.[930]

In his book, Insel takes on the role of a drug salesman, selling the wonders of psychiatric drugs to the public, but it is misleading and dishonest. It starts already with the title. Psychiatric drugs cannot heal mental disorders, and the path the psychiatrists have taken is not from mental illness to mental health, but from bad to worse. If you read the book with open eyes and see through all the window dressing, it becomes clear that it makes an unintended case for abolishing psychiatry even though Insel tries to support it.

NIMH is the most prestigious institution in the world in mental health. Bob Whitaker has therefore taken a close look at the book.[931] It reflects the thinking of psychiatric leaders everywhere and encapsulates how psychiatry has consistently betrayed public trust and misinformed the public, and that it will never tell the public the truth about psychiatric

drugs. Bob concludes that the real source of the poor mental health outcomes in the USA is the psychiatric establishment, including the NIMH, which – although being a governmental agency – cannot be trusted.

Being a former NIMH director, Insel had an obvious ethical obligation to tell his readers about the poor long-term outcomes of treatment with psychiatric drugs, as documented in expensive and prestigious research funded by the NIMH, e.g. the STAR*D trial in depression, the MTA trial in ADHD, and the CATIE trial in schizophrenia (see earlier chapters). He didn't, even though NIMH was the only institution in the world that funded the big, long-term drug trials, the drug companies never funded because they didn't need to and likely also because they anticipated that the results would not be positive.

This made it even more deplorable that Insel avoided commenting on them. The public expects a medical specialty to be an honest purveyor of scientific findings about the benefits and harms of its interventions, and if the trial results tell of treatments that *worsen* long-term out-comes, then the medical specialty must inform the public about it and rethink its practices.

For 70 years, psychiatry has failed to do this. Insel could have remedied this betrayal of public trust with his book and put psychiatry on a new path, but as psychiatric leaders always do, he sacrificed the patients and protected the psychiatric guild by keeping the long-term studies financed by his own institute hidden. The betrayal cannot be worse than this. All the really large drug trials in psychiatry have been negative, which must have agonised the key opinion leaders in psychiatry, but the facts have not led them to change their false public announcements or harmful guidelines.

Before Bob wrote his book about the astonishing rise of mental illness in America,[932] he dug through the research literature. With each class of drugs, he tried to find out what the clinical course was before and after the introduction of drugs, and if the medicated or unmedicated patients had better long-term outcomes in clinical studies. He found that depression pills, psychosis pills, and benzodiazepines worsen long-term outcomes, and that bipolar disorder, which is regularly treated with polypharmacy, runs a much more chronic course than manic depressive disorder - the diagnostic precursor to bipolar - once did.

This fits all too well with Insel's information that the number of adults in the USA receiving a social security payment due to a mental disorder rose from around 1.3 million in 1987 to around 6 million today. This is not a "path from mental illness to mental health."

Bob's book is very convincing. There was of course a great deal of pushback from prominent psychiatrists when it came out, but when a filmmaker interviewed Insel five years later and asked him about the book, he responded that Bob's observations needed to be taken very seriously and noted that, in other areas of medicine, if you increase the use of your medication several times, you will see reductions in morbidity and mortality.[933]

This short glimpse of sanity and self-insight in psychiatry quickly disappeared.

In the first chapter of his book, Insel asked why more treatment was associated with more deaths and disability. But, in a most appalling fashion, he dismissed any worry that psychiatric drugs could be the cause of the poor outcomes. He used the tactic, philosopher Arthur Schopenhauer in *The art of always being right* calls making a diversion.[934] He suddenly changed subject. He wrote that Bob argues that drugs against depression and psychosis create a "supersensitivity" that makes patients dependent and chronically disabled. This is a red herring. Whether supersensitivity occurs or not (which it does, see below) is immaterial for Bob's findings.

Insel claimed that Bob writes that the psychiatric establishment, in collaboration with the pharmaceutical industry, has conspired to overmedicate and overtreat children and adults with disastrous results, and that not everyone buys this conspiracy theory.

Insel is both evil and mendacious. The only time Bob used the term conspiracy in his book was when he quoted a patient with schizophrenia who spoke about conspiracies. Insel used the diversion trick again and another of Schopenhauer's tricks: "Postulate what has to be proven." Insel is good in the art of always being right.

Insel turned sand into gold by making yet a third horrific diversion. He claimed that current treatments are necessary but not sufficient to cure complex brain disorders. This mumbo jumbo has absolutely no bearing on the case. He quoted his predecessor Steven Hyman who said we need to know much more about the biology of mental illness before we can illuminate a path across very difficult scientific terrain and develop medications that are as effective as insulin or antibiotics.

Insel covered up for the fact that biological psychiatry has been a total failure. Furthermore, his ill-founded fantasies about a better future do not remove the immense harm his specialty inflicts on hundreds of millions of people.

Insel went further into wonderland. He thinks clinicians are more effective today than they were 25 years ago. Yes, indeed. They are harming their patients more than ever!

Insel's diversions and dishonesty multiplied. He noted that most people with mental illness are not treated; that many of those receiving drugs do not take them; and that patients receive little more than drugs. He cleverly put the blame for the poor outcomes on society for not investing in necessary social supports and on patients for failing to take their drugs and stay engaged in treatment.

This is the standard script for psychiatrists. The disaster they have created is not their fault. Others are to blame, including the patients and society. Insel conveniently ignores that, if more patients took their drugs, the disaster would become even worse.

Insel describes himself as taking on the role of a journalist as he explores humanistic supports that are needed to complement drugs to promote lasting recovery. This is a win-win position. Anyone will welcome social support, and Insel positions himself as the advocate for this societal response. This is manipulation at the highest level.

Nothing in Insel's narrative is harmful to psychiatry's guild interests or the interests of the pharmaceutical industry. Instead of criticising the drugs, he praises them. He claims that psychiatric drugs, ECT, and transcranial magnetic stimulation work and that depression pills have an effect size that is often higher than medications used in other areas of medicine. A remarkable statement about drugs that have no clinically relevant effects.

My view on this type of argument is that one unlawful parking doesn't make the next unlawful parking lawful. There are many ineffective drugs that shouldn't be used.

Insel doesn't cite a single study that tells of psychiatric drugs providing long-term benefit, perhaps because they don't exist. His book is a superb example of *The Emperor's new clothes*. The Emperor is naked but so well dressed up that few readers will notice it.

The Emperor's New Clothes

Psychologist Bruce Levine wrote in 2024 that "exuberant individuals who disregard societal consensus reality are routinely diagnosed by psychiatrists with bipolar disorder; however, among psychiatrists themselves, exuberance about psychiatry regardless of the reality of psychiatry's repeated scientific failures makes one a leading psychiatrist."[935]

Bruce says that, in the 21st century, there has been no higher-level psychiatrist than Thomas Insel who is a prime example of an exuberant psychiatrist. He pushed neuroscience and genetics and got papers published at a cost of about $20 billion, and even though this did not result in anything useful for the patients, he has no regrets about NIMH funding all this. Moreover, Insel wrote in his book that "The idea of mental illness as a 'chemical imbalance' has now given way to mental illnesses as 'connectional' or brain circuit disorders." This is plain nonsense, with no supporting evidence.

In his book review, Bob provided a highly revealing summary of studies Insel didn't dare mention. I present below some examples.

After psychosis pills were introduced in the mid-1950s, clinicians began speaking about the "revolving door syndrome" that now appeared in asylum medicine. First-episode patients would be discharged and then return in droves, which led the NIMH, during the 1970s, to fund four studies to assess whether psychosis pills were increasing the chronicity of psychotic disorders.

Bockoven[936] reported that the rehospitalisation rate was higher for patients treated after the arrival of psychosis pills and the medicated patients were also more socially dependent than those treated before 1955. Carpenter,[937] Mosher,[938] and Rappaport[939] reported superior outcomes for unmedicated patients after 1–3 years, which led Carpenter to suggest that antipsychotic medication may make some schizophrenic patients more vulnerable to future relapse. Back then, other researchers wrote about the adaptive brain changes stirred by psychosis pills and concluded that drug-induced dopamine supersensitivity leads to dyskinetic and psychotic symptoms and an increased tendency to relapse.[940]

Nancy Andreasen, funded by NIMH, reported in a large MRI study of patients with schizophrenia that psychosis pills shrink the brain, which is associated with a worsening of negative symptoms, increased functional impairment, and cognitive decline.[941]

In the late 1970s, with funding from the NIMH, Martin Harrow and Thomas Jobe launched a long-term study of 200 patients, most of whom were experiencing a first or

second episode of psychosis. By year two, the outcomes of those who got off their psychosis pills began to dramatically diverge from those who stayed on the drugs, and after 15 years, the recovery rate for the off-med patients was eight times higher than for the medication compliant patients (40% versus 5%).[942]

In the past two decades, long-term studies of psychotic patients conducted in Holland (a randomised trial of drug discontinuation, see page 148),[943] Finland,[944] Australia,[945] Denmark,[946] and Germany[947] all told of higher recovery rates for those off drugs. A systematic review of qualitative studies supported this: The patients tell of how the drugs compromise functional recovery.[948]

The history of depression is much the same. Studies of hospitalised patients showed that, prior to the introduction of depression pills, depression was an episodic disorder, and around half of the patients who suffered a first episode would never be rehospitalised. After the introduction of depression pills, several studies found high relapse rates, and an NIMH expert panel concluded that, in contrast to older studies, new studies had demonstrated the recurrent and chronic nature of depression.[949] The elephant in the room was ignored.

Two NIMH studies in real-world patients treated in outpatient settings confirmed that chronicity was the long-term course for medicated patients. The STAR*D trial,[950] with its 3% stay-well rate at the end of the one-year follow-up on depression pills stood in sharp contrast to another NIMH funded trial that studied the long-term outcome of untreated depression. In that study, 85% of the included 84 patients had recovered by the end of one year.[951] The researchers concluded that "it would be extremely difficult for any intervention to demonstrate a superior result to this."

Many studies over the past 40 years have compared outcomes for medicated and unmedicated patients over longer periods of time.

In an NIMH study that randomised 250 patients to imipramine or to psychotherapy or placebo, the stay-well rate was highest for cognitive therapy (30%) and lowest for imipramine (19%) and placebo (20%) after 18 months.[952]

In an NIMH study of 547 patients, the treated patients were three times more likely than those who eschewed medical treatment to suffer a cessation of their principal social role, and nearly seven times more likely to become incapacitated after six years.[953]

A WHO study of 640 depressed patients found that those treated with medication had worse general health and were more likely to still be mentally ill than those who weren't treated at the end of one year.[954]

A Canadian study of 1281 people who went on short-term disability due to a depressive episode found that 19% of those who took a depression pill went on to long-term disability compared to 9% of those who never took such medication.[955]

In a five-year study of 9508 depressed patients in Canada, medicated patients were depressed on average 19 weeks a year versus 11 weeks for those not taking drugs.[956]

Two reviews of patients diagnosed with depression found that use of a depression pill was associated with worse outcomes at nine years[957] and at 30 years.[958]

As these findings have piled up, researchers - led by Italian psychiatrist Giovanni Fava - have pointed to drug changes induced by depression pills as a likely explanation for the "bleak long-term outcome of depression ... use of antidepressant drugs may propel the illness to a more malignant and treatment unresponsive course."[959]

American psychiatrist Rif El-Mallakh observed that 40% of patients treated with a depression pill ended up in a chronically depressed "treatment resistant" state.[960] He wrote

that drug treatment may induce processes that "cause a worsening of the illness, continue for a period of time after discontinuation of the medication, and may not be reversible."

Given this literature, it is no surprise that depression is now the leading cause of disability in the USA for people ages 15 to 44, and that in country after country that has adopted widespread use of SSRIs, the number of people on government disability due to a mood disorder has increased in lockstep with the increased use of these drugs.[961]

Long-term ADHD studies in Australia[962] and Quebec[963] also found worse outcomes for medicated youth than for those treated without stimulants.

As Bob noted, the science shows that pills for psychosis and depression increase the chronicity of the disorders, and the same is true for stimulants, benzodiazepines, and drugs used for bipolar disorder. There is a list of over 100 papers that tell of these outcomes on the Mad in America resource pages.

None of the above is found in Insel's book or on NIMH's website. A search for Martin Harrow on the website shows nothing even though he was considered one of NIMH's experts on schizophrenia. A search for STAR*D shows the press release about the short-term results that tells of "particularly good results" with depression pills.[964] And the website information about ADHD[965] does not inform parents that in the MTA study, medication use was a marker of deterioration by the end of year three, and that those taking stimulants had worse ADHD symptoms and were more functionally impaired at the end of six years.

In 2015, Bob and his wife Lisa Cosgrove published *Psychiatry under the influence*,[966] a book that arose from their time as fellows at the Safra Center for Ethics at Harvard University, devoted to studying institutional corruption.

We expect that institutions that serve a public interest - and this is particularly true for medical disciplines - will adhere to ethical standards such as rising above financial influences; will be objective and accurate when designing, analysing, interpreting and reporting the results of studies; and will put the interests of patients first. Accordingly, Daniel Wikler, a professor of ethics at the Harvard School of Public Health, wrote that a medical discipline that fails to adhere to this standard doesn't deserve to retain its privileged place in society.[967]

The erosion of basic ethical principles is complete for psychiatry. If the psychiatric profession told the public the truth, psychiatry would collapse. The profession needs to keep the truth out of sight, even to itself, and it is not presented in psychiatric textbooks, in lectures or in public debates. Insel's book is a gravestone for psychiatry. It is a work of propaganda for a sick system, praising harmful treatments as if they were beneficial.

More about not listening to people

In 2013, during a lecture tour in North America, I lost my way at a large hospital in Baltimore.[968] I couldn't find the auditorium and the organiser didn't answer her phone. I strolled around in despair while the time for my lecture was rapidly approaching.

As a last resort, I bypassed a large queue of patients at the hospital reception, as I was in a hurry, and explained to the receptionist that I was not a patient, but a doctor scheduled to give a lecture in a few minutes time.

"Please go to the end of the queue," she replied with a stone face. I repeated that I was a doctor and asked for help to find my colleague who worked at the hospital.

"Please go to the end of the queue," the robot replied. It didn't matter to her how much I begged for help. As she didn't tell me the hospital information desk was close by, she might have thought I was a psychiatric case with the delusion that I was a doctor.

After having asked a friendly person in the corridor where the hospital information desk was, I arrived in the auditorium at the very last minute. It might have traumatised me, as I still have nightmares about being called to the podium without having arranged my slides, and sometimes even without having them with me.

When I arrived at the McMaster Hospital in Hamilton, I lost my way again. My colleague, Gordon Guyatt, had given me some instructions, but it was very difficult to find his office. I told the receptionist that I was a doctor and had an appointment with a colleague. After much trouble and disbelief, she reluctantly made a connection, and Gordon came down to pick me up.

He was on call, and when his pager howled a little later, I said jokingly that it was the receptionist who would tell him that his patient - me - had arrived. Quite so. I had become a patient once more, and my title as a doctor was disbelieved again.

With such attitudes to colleagues, it is easy to understand why psychiatric patients can become very frustrated when they are distrusted and why violence is sometimes triggered by the staff's disrespectful behaviour. Psychiatrists routinely refuse to trust what patients tell them about their bad experiences with the drugs they prescribe.

Danish philosopher Søren Kierkegaard wrote in 1859: "In order truly to help someone else, I must understand more than he - but certainly first and foremost understand what he understands. If I do not do that, then my greater understanding does not help him at all. If I nevertheless want to assert my greater understanding, then it is because I am vain or proud, then basically instead of benefiting him I really want to be admired by him. But all true helping begins with a humbling. The helper must first humble himself under the person he wants to help and thereby understand that to help is not to dominate but to serve, that to help is not to be the most dominating but the most patient, that to help is a willingness for the time being to put up with being in the wrong and not understanding what the other understands."

Few psychiatrists practice psychiatry in this way, humbling themselves. Grandiosity is more common (see next section). A commentator wrote on Mad in America that psychiatry is predicated on how the psychiatrist "feels" about the patient and not how the patient feels. It is opinion based "medicine."

Psychiatrists could improve a lot if they were willing to learn from their mistakes and to listen to their patients. Internet surveys of patients' experiences have revealed that drug harms are far greater and much more common than reported in the randomised trials, even though those who respond are generally quite positive to the drugs.[969]

A previous patient wrote:[970] "I have experienced wonderful people who work in psychiatry. But I have also experienced absolutely horrible people and everything in between. The worst have been those who sit with professional distance where they can neither give a little of themselves as a person nor have empathy for others. Far more people with user experience need to enter psychiatry, while those with anti-empathic professional distance must go."

I have learned a lot from the thousands of people, including progressive psychiatrists, that have sent me extraordinary stories about a specialty in ruins. Many patients and relatives have reported how badly they were treated by psychiatrists, sometimes with

derogatory comments in the files about their personality, e.g. if they tried to avoid having their child treated with psychosis pills.

Some have thanked me for saving a life, e.g.: “It was your book that gave us the courage to withdraw our son from antipsychotics.” I later met with this person who is very active in the withdrawal community.

A patient who thanked me for having saved her life wrote that if she had not read my books and learned that there is something called withdrawal, she would have thought she had become insane.

Another patient wrote that her depression pill for shyness had made her life miserable. It changed her personality into being angry, and disrespectful, and she lost many friends and her trust in psychiatry, drug companies and doctors. She noted that the number of members in her SSRI withdrawing group increased steadily.

A family doctor used depression pills as a diagnostic test: If they worked, you had depression, and if not, you did not have depression. One would think it couldn’t be more primitive than this, but another family doctor responded to a question about how to stop a depression pill: “You can just stop!”

A patient who had tried to withdraw twice from her depression pill in vain was told by her psychiatrist that she had a chemical imbalance and needed the drug for the rest of her life, and her psychiatrist even increased the dose. A substitute for her family doctor saved her. He said that the pills were devilry and made her sick, and he helped her withdraw. She wanted to help others because she worked as a job consultant with unemployed people, many of whom got hooked on the pills because of stress and anxiety.

A father was denied custody of his children because he refused to take psychiatric drugs. If not illegal, it should be.

One patient wrote to me that a test showed her IQ had dropped to 70, but this was while she was doped when an IQ test is meaningless.

Another wrote that her psychiatrist had told her she had an incurable genetic disease, and when she complained that she could no longer concentrate, slept a lot, and had memory issues, the reply was that the problem wasn’t the drugs but that she lost neurons due to psychosis! She therefore needed to take psychosis pills indefinitely to protect her neurons; otherwise, she would become demented. When she said she didn’t want to take the drugs for the rest of her life, the psychiatrist replied that she would not see her anymore because she only worked with patients who wanted to be treated. When she had withdrawn the drugs, she was told she would have a new psychotic episode. Her father wanted to force her to go back on medication and threatened to send her to a mental hospital if she didn’t follow the doctor’s instructions. She lied to him saying she took the drugs again. Today, she is fine, having escaped the tyranny of incompetent psychiatrists and dumb relatives.

A patient wrote she had been advised to be on drugs for the rest of her life. When she told her doctor that they had caused anorgasmia, the doctor said: “Which do you prefer, not having orgasms or going mad?” She realised something was wrong and decided she did not want to live chemically castrated as if she had undergone a lobotomy. After she had stopped all the drugs, she became herself again. She was no longer a zombie, was back to listening to music, laughed, sang in the shower, felt life, and had sexual pleasure. She had been sexually abused as a child, which is a common cause of psychosis.

A patient had taken fluoxetine (Prozac) for ten years, which changed his personality, and he lost almost all his friends. He went through a horrible withdrawal without help where he couldn’t even get out of bed. His doctor told him that psychiatric drugs were vital for him,

like insulin for diabetes, and he started on a drug again, but tolerated it badly. Then, his psychiatrist said that his ill effects were likely caused by his depression, and he wanted him to try another drug. This patient had attended one of my lectures in Stockholm and therefore knew I had a list of people who could help him withdraw.

An 18-year-old student was still grieving after his father hanged himself five years earlier. After he was put on sertraline (Zoloft), he tried to hang himself and a psychiatrist admitted him to a psychiatric hospital and increased the dose of sertraline. When a young psychiatrist noted that depression pills increase the risk of suicide, the consultant replied that they were aware of this but had to treat depression. If the student committed suicide without being on a depression pill, they would be questioned why he was not treated.

A middle-aged man with symptoms of pneumonia and a low mood was put on penicillin, sertraline and a sedative by his family physician. He developed psychosis with mania, was admitted to a psychiatric hospital and treated with olanzapine (Zyprexa). When a young psychiatrist asked if the psychosis could have been caused by sertraline, he was told: "I've never seen anybody with antidepressant-induced psychosis."

David Stofkooper from Holland took his life in 2020, only 23 years old. He had a flourishing social life, was a lively, very intelligent student, with a lot of friends, enjoyed socialising and loved listening to music. Since he was 17, he ruminated a lot but had a fun life.

He made the fatal mistake of consulting a psychiatrist who put him on sertraline (Zoloft). Within two weeks, he became suicidal, but his psychiatrist increased the dose, and it got worse. He became zombified, with no libido and no emotions; his whole personality had disappeared.

His mother called his psychiatrist and said the drug definitely didn't work, but she was fobbed off, being told she couldn't call due to her son's privacy. Her intervention was badly needed, as David didn't notice what was going on; he had lost himself totally.

David told his psychiatrist that he was very suicidal, but the psychiatrist said he needed to wait longer, so he believed in that.

After five months, he got a new psychiatrist who told him to quit sertraline cold turkey, in just two weeks. At first, he got a one-day long mania and told his mother he hadn't felt so awesome before. But after that, he got into horrible withdrawal, which went on for months. When he told his psychiatrist how he felt, she didn't believe him and said it was not due to the drug, as it was out of his system. She opined it was probably his obsessive, compulsive disorder that created all the problems.

David wrote in a suicide note that, "You present them with a problem that is created by the treatment you got from them, and as a reaction, get blamed yourself."

His life had stopped. He couldn't get pleasure out of anything. Although he didn't feel anything by meeting girls anymore, his zero libido and erection problems weren't even the worst part. It was "The total erasing of any pleasure in life."

When he realised, he was doomed to be in this state forever, he saw no other option than suicide. He was very rational about it, and his parents, who are both doctors, understood him.

The blunting of his emotions was fatal. He felt he was already dead, an empty shell. David had never had any sleeping problems before he took sertraline, but the drug caused severe insomnia, which lasted till the day he killed himself.

David wanted his story to be told, as a warning to others. Both he and his mother had read my first psychiatry book, but unfortunately, it was too late. If he had read it before he was put on sertraline, he might have refused to take the drug that killed him.

I have heard similar stories, also from Denmark, where the patients killed themselves because their sex life became permanently destroyed, and where they also experienced severe anhedonia (inability to feel pleasure), flatness of emotions, memory problems and cognitive dysfunction, which some of them described as a chemical lobotomy.

Patients who have come off psychosis pills have also sometimes complained of persistent sexual dysfunction. There is still a lot we don't know about the persistent harms of psychiatric drugs. But what we do know is that psychiatry is insane, which child and adolescent psychiatrist Sami Timimi wrote a book about.[971]

Are psychiatrists more mad than their patients?

When I discuss psychiatry with critical psychiatrists, psychologists or pharmacists I collaborate with, we sometimes wonder who are most mad, the psychiatrists or their patients?

It looks like a rhetorical question or a joke, but it isn't. When I googled "delusion," an Oxford dictionary said: "An idiosyncratic belief or impression maintained despite being contradicted by reality or rational argument, typically as a symptom of mental disorder."

The World Health Organization's International Classification of Diseases (ICD) has this definition: "A belief that is demonstrably untrue or not shared by others, usually based on incorrect inference about external reality. The belief is firmly held with conviction and is not, or is only briefly, susceptible to modification by experience or evidence that contradicts it. The belief is not ordinarily accepted by other members or the person's culture or subculture (i.e., it is not an article of religious faith."

The DSM-5 defines delusions as "fixed beliefs that are not amenable to change in light of conflicting evidence. Their content may include a variety of themes (e.g. persecutory, referential, somatic, religious, grandiose) … Delusions are deemed bizarre if they are clearly implausible and not understandable to same-culture peers and do not derive from ordinary life experiences."[972] Common types of delusions are:

- persecutory (people believe they are at risk of being harmed because of the malevolent intentions of others),
- reference (people believe that innocuous events, e.g. the gestures of strangers or radio news bulletins, are being deliberately targeted at them),
- grandiose (may concern special identity or abilities, extreme wealth or a special mission and are associated with a strong need for meaning and purpose in life),
- control (people believe that their acts, motivations or emotions are under the control of another agency),
- religious (may concern a special relationship with God or gods but also sometimes involve claims of a special religious identity such as being Jesus; these kinds of delusions are notoriously difficult to distinguish from nonpathological religious beliefs).

These definitions make it clear that psychiatry is characterised by delusions. As I have shown in this book, the psychiatrists' predominant idiosyncratic beliefs are not shared by people considered sane - the general public - but the psychiatrists forcefully maintain them, even when reality, including the most reliable science we have, and rational argument or logic clearly show that their basic beliefs are wrong.

When people criticise psychiatry, they are often called "anti-psychiatry" or conspiracy theorists, reactions which seem to have a persecutory delusional element.

Grandiosity is a sense of superiority, uniqueness, or invulnerability that is unrealistic and not based on personal capability. Many psychiatrists behave in a grandiose way, believing in their own omnipotence and infallibility and that they have a special insight no one else has. If others don't agree, they are seen as ignorant, in need of education. During Joseph Biederman's testimony in a court case in 2009, an attorney asked him about his rank at Harvard Medical School. Biederman replied: "Full professor." "What's above that?" the attorney asked. "God," he replied.[973]

Faith is a great trust or confidence in something for which there is no proof, or an unshakeable belief in something even if there is proof against it. Clearly, the psychiatrists' beliefs in what they are doing are more of a religious nature than they are scientifically founded, which makes psychiatry a pseudoscience.

Psychiatrists have an unshakeable belief in the great benefits of their drugs, electroshock and forced treatment, despite the proofs of the lack of benefit and the existence of serious harms. Members of religious cults don't listen to evidence that could shake their beliefs; they suppress it, distort it, or lie about it. Some critical psychiatrists find that psychiatry is a religious cult where people are excommunicated for thinking for themselves.

One definition of madness is doing the same thing again and again expecting a different result. When a drug doesn't seem to work, psychiatrists increase the dose, change to another drug from the same class, add another drug from the same class, or add a drug from another class. The science tells us that these manoeuvres will not benefit the patients. Switching drugs, adding drugs or increasing the dose do not result in better outcomes.[974]

Increasing the total dose or the number of drugs will increase the occurrence of serious harms, including irreversible brain damage, suicides and other deaths,[975] but psychiatrists often lie to their patients telling them that their disease might harm their brains, or they might die, if they don't take their drugs. This is perverse.

Unfortunately, the madness is getting worse. In office-based psychiatry in the USA, visits with three or more drugs doubled, from 17% to 33%, in just nine years, and prescriptions for two or more drugs from the same class also increased.[976] The use of psychiatric drugs and polypharmacy for children and adolescents were twice as high in 2021 as in 2013 in Australia,[977] and the use of neuroleptics increased by 45% in just six years.[978] In the UK, psychosis pill prescriptions increased by 5% per year on average and depression pills by 10%, from 1998 to 2010.[979] In Denmark, the sales of SSRIs increased from a low level in 1992 almost linearly by a factor of 18, closely related to the number of products on the market that increased by a factor of 16 ($r = 0.97$, almost perfect correlation).[980] This confirms that drug usage is determined by marketing.

The mortality for patients with schizophrenia has increased markedly compared with the general population; the median standardised mortality ratio for the 1970s, 1980s and 1990s were 1.84, 2.98 and 3.20, respectively.[981] The authors noted that an obvious explanation for this development is the increased use of newer psychosis pills, which are more likely to cause weight gain and metabolic syndrome than the old drugs.

Two textbooks Denmark mentioned that several psychosis pills may be needed simultaneously, and one noted it may be appropriate in some cases to increase the dosage above the approved interval, which has the same deleterious effects as using several drugs.

In 2006, a report from the Danish Board of Health showed that half of the patients were in treatment with more than one psychosis pill simultaneously,[982] although both national and international guidelines recommend against it. The record I know about was seven

psychosis drugs used simultaneously. However, the Danish Ministry of Health issued a licence to kill in 2014. It allowed psychiatrists to use extraordinarily large doses of psychosis drugs for forced treatment and said that this applies especially to patients who have been in prolonged treatment and where smaller doses have been tried without success.[983]

This is as mad as it gets. This risk of death is of course dose related.[984] The psychiatrists don't realise that when a patient is "treatment resistant," which is an insulting term as it suggests that the patient is at fault and not the drug, they should not increase the dose or add another drug but taper off the first drug slowly, which will have the best outcome. But psychiatric leaders care little about patient safety. They care more about their own reputation, the guild they represent, and the flow of money from drug companies. This corruption permeates our authorities, which rely heavily on specialists when issuing guidelines, and they only make changes if critics make a lot of public noise about the wrongs.

I have witnessed the madness directly in psychiatric departments. I was once invited to follow the chief psychiatrist during one day at a closed ward at my hospital, Rigshospitalet. One of the patients appeared totally normal and reasonable to me, but the psychiatrist considered him delusional. As I couldn't see this, he explained the patient was delusional because he had been on the Internet and had found out that psychosis pills are dangerous! I was so stunned that I said no more.

On another occasion, I phoned Psychiatric Centre Amager, which has a particularly bad reputation because the psychiatrists have killed several of their patients with drugs.[985] A patient in great distress had contacted me, but I couldn't get a psychiatrist on the phone, even though I explained I was a colleague, and it was within normal working hours.

I insisted I needed to talk to someone and was transferred to a head nurse. She told me not to become involved because the patient was delusional. When I asked in what way, she said he had found out that psychosis pills are dangerous! I asked if she knew who I was. Oh yes, she did, but that didn't stop her from exposing psychiatry's insanity.

In 2023, the whole Board of the Norwegian Psychiatric Association felt so threatened by colleagues who wanted a radically different psychiatry that they published an opinion piece to defend the *status quo* in a newspaper, *'Pill shaming' is a serious societal problem*.[986]

I explained the worst falsehoods in their misguided defence of psychiatric drugs,[987] which is typical of leading psychiatrists everywhere. They denied that the drugs change the personality (which is the reason for using them and which many patients have experienced), have greater side effects than other drugs (they are the third leading cause of death!) and are unnecessary (almost all of them are). "Conspiracy theories abound that the pharmaceutical industry only wants to profit on making people as dependent as possible" (it is not a conspiracy theory that the drug industry doesn't care about the harms it causes but only about its profits; it is a fact).

"Drug treated patients return to work more quickly, and disability can be prevented" (a horrific lie, as the opposite is true).

"The prognosis and risk of relapse are improved significantly when patients take antipsychotics" (the trials that provide the basis for this misconception are deeply flawed).

"Patients with ADHD often have reduced quality of life, more frequent depression and more drug problems and criminal behaviour if they are not treated" (this is not true, and in the long run, the opposite is true).

"Drug treatment makes patients more accessible to psychotherapy" (this has not been documented and is unlikely to be true; and if the drugs have caused permanent brain damage, psychotherapy cannot restore it).

"There is no biological basis for saying that commonly used psychiatric drugs such as antidepressants, mood stabilizers and antipsychotics cause dependence" (another horrific lie; the drugs up- or downregulate neurotransmitters in the brain, which is why abrupt withdrawal can cause terrible and dangerous withdrawal symptoms).

"So far, most studies indicate that drug treatment is absolutely necessary to achieve recovery and increase quality of life and prevent relapse for most patients with severe psychiatric disorders" (these statements are also blatantly false).

The misconceptions among psychiatric leaders are so much at variance with the scientific evidence, and with what the patients and their relatives and others experience, that it seems justified to say that the psychiatric leaders suffer from a very serious, collective delusion.

Delusions are a key symptom for psychosis. People's thoughts and perceptions are disrupted and they have difficulty recognising what is real and what is not.

So, here is a thought experiment. Using the psychiatrists' own diagnostic systems and practice, it can be argued that psychiatric leaders such as the Norwegian authors of the opinion piece should be forcefully treated with neuroleptics. If they tasted their own medicines, which some doctors have done to see what it was like,[988] few of them would sustain their delusions about how good they are, which would benefit mankind.

One of the psychiatrists I admire and have met with is Niall McLaren from Australia. He sent a letter to a family doctor about a 21-year-old student, discharged from a private hospital after 21 treatments with transcranial magnetic stimulation, which he calls "the latest in a long line of crackpot fads to hit psychiatry, designed to separate the worried well from their money." I agree. It doesn't seem to work.[989]

The poor student also received 12 electroshocks because of anxiety and was discharged with three different psychosis pills, three different antiepileptics, two different depression pills, a sleeping pill and lithium. She suffered tremendously from this drug cocktail and had akathisia. And yet, her only problem was anxiety!

Niall wrote to her family doctor that "If she stays on this level of drugs, she will be dead by forty."

I was an expert witness in a court case in Australia, which also illustrates psychiatry's insanity. It shows the role of depression pills as "Psychiatry's Starter Kit" that quickly leads to more diagnoses and dangerous drug cocktails.

A young man who should have been offered psychotherapy for his transient problems was functioning well when his psychiatrist put him on a depression pill for a depression he didn't have.

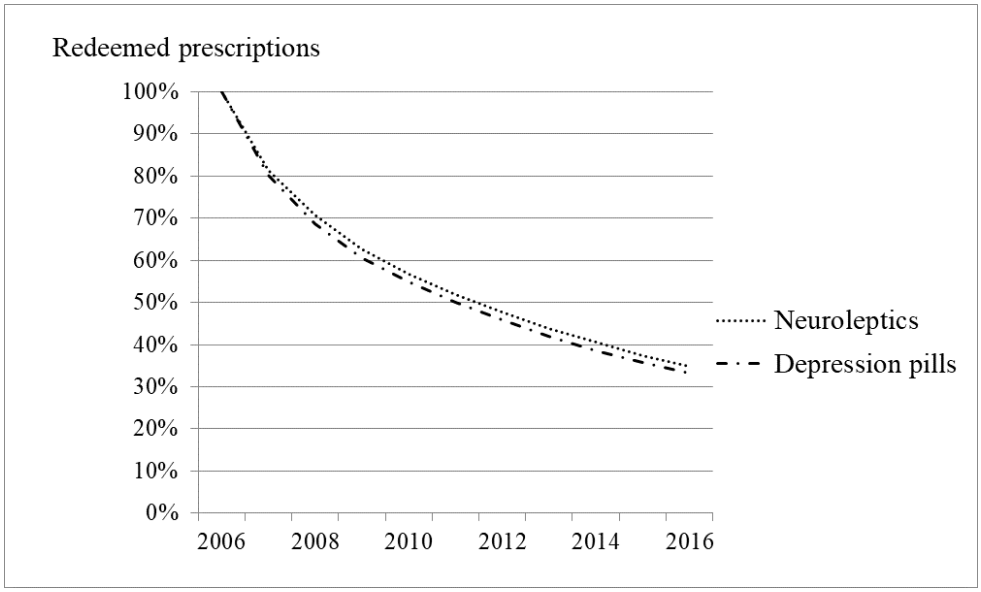
His psychiatric "career" lasted 33 years before he finally succeeded to come off the last drug, but he still suffers from long-lasting withdrawal effects. He was prescribed a total of six different psychosis pills, five depression pills, and three different sedatives/ hypnotics, and developed Parkinsonism, likely drug induced. His psychiatrist stopped the drugs abruptly many times, which is highly dangerous. It is a remarkable feat that he survived this malpractice and continued being employed.

He should win the case easily, but unfortunately, judges are authoritarian and emphasise what other psychiatrists do in similar situations. This is a mad system. If a bank defrauds its customers, the argument that other banks do the same won't win much sympathy.

Occasionally, a case is won. Wendy Dolin in Chicago, whom I have met several times, sued GlaxoSmithKline after her husband, a highly successful lawyer who had no psychiatric issues, was put on paroxetine because he developed some anxiety regarding work. He got akathisia and threw himself in front of a train six days after starting paroxetine, not realising it wasn't him that had gone mad; it was the pill that had made him mad. I have also met with Wendy's lawyer, Michael Baum from Los Angeles, several times. His law firm won the case, but GSK appealed, and the upper court annulled the verdict, not because they didn't think it was akathisia, but they put the blame on the FDA. Wendy told her story at my international meeting in Copenhagen in 2015.[990]

Now, let's look at how psychiatric drugs are used. If usage was sane, the usage patterns ought to be very different for pills against psychosis and depression because the main indications, schizophrenia and depression, respectively, are very different, the former being traditionally perceived as a chronic condition and the latter as episodic.

However, I found that the usage patterns are identical (see figure).[991]



I started the clock in 2006, when 80% of the patients in both groups had already been on a pill for one or more years. The graph shows the percentage of patients that got a new prescription every single year till they stopped or came to 2016, my last observation year, when 35% vs 33% of the patients were still in treatment.

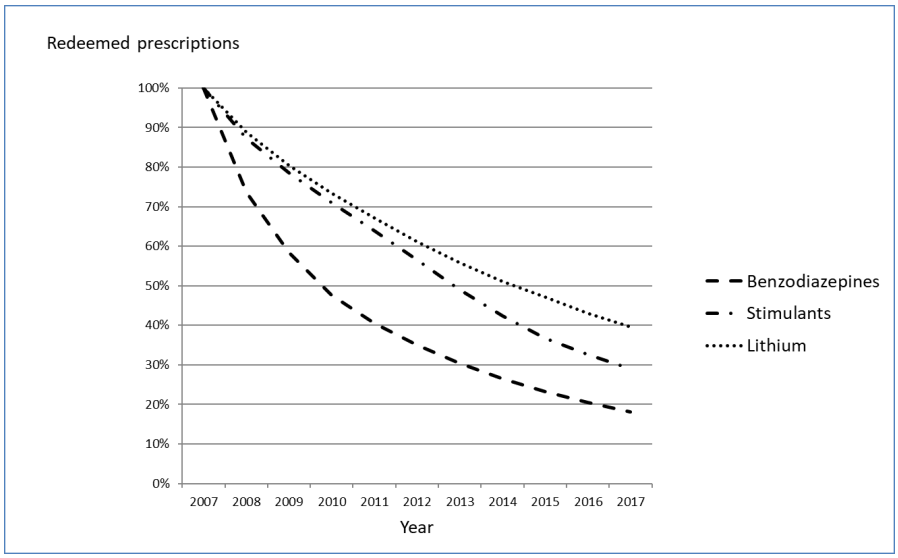
These results are shocking. Drug usage is clearly not evidence-based, and many patients continue taking their drug, year in and year out, for more than a decade. This is iatrogenic harm of epic proportions that tells a story of incompetent and irresponsible doctors who don't know what they are doing or what they are causing.

In 2014, Norwegian psychiatrists wrote about an "alarmingly high discontinuation" rate of psychosis pills in patients with schizophrenia, 74% in just 18 months. I would call this a healthy sign, but the psychiatrists argued it highlighted "the clinicians' need to be equipped

with treatment strategies that optimize continuous antipsychotic drug treatment."[992] Wanting to increase the harms for no benefit is insane.

Next, I studied the usage patterns for benzodiazepines and similar agents, and lithium and stimulants (ADHD drugs). Since we have known for decades that benzodiazepines are highly addictive and should only be used for a few weeks, also because the therapeutic effect disappears quickly, usage of such drugs ought to be very low and transient, but this is not the case.[993]

For benzodiazepines, only 13% were first-time users in the first observation year (for the two other classes of drugs, these numbers were 40% and 11%, respectively), and the usage patterns, were once again, shocking.



No matter which drug people take or what their problem is, roughly one-third of the patients are still in treatment with the same drug or a similar one ten years after several of them have already been treated for one or more years.

If we accept the evidence-based premises that none of these drugs have clinically relevant effects when used long term, and also consider their substantial harms, and that the patients generally dislike them, the data show an insane overuse of psychiatric drugs.

If you criticise the mad system, you get in trouble. When Scottish psychiatrist Peter Gordon in 2019 expressed his views about psychiatric overmedication, the chair of the Scottish Division of the Royal College of Psychiatrists phoned the Associate Medical Director of the NHS Board where Gordon worked and expressed concerns about his mental health.

Many of us have experienced to be "diagnosed" by our psychiatric opponents. For me, it happened during a court case where I was an expert witness (see page 49);[994] in a conversation between two psychiatrists at a private party one of my friends overheard; and in a newspaper where Henrik Day Poulsen called me paranoid[995] after I had published my book about organised crime in the drug industry.[996] Poulsen, likely the most corrupt psychiatrist in Denmark, as he collaborated the most with drug companies,[997] has also called me "anti-psychiatry"[998] and diagnosed me without having ever met with me. He has published the book, *Drugs that kill* about corruption and greed in the drug industry, but he doesn't see the irony that he participates in this.[999] When I lectured in 2014 about happy pills, a previous

patient said that Poulsen had written an autobiography. When I asked what it was, she said it was his book, *Everyday psychopaths*.

Half a year later, Poulsen triumphantly declared, in the same newspaper, with the headline: *Witch hunt after the drug industry*, that I had lost my case against him in the Ethical Council for Doctors, and he repeated that I, for a long time, had created a paranoid emotion against the drug industry.[1000]

He didn't say what the case was about but pretended it had to do with my criticism of the drug industry, as if it was unfounded, which was dishonest. And he celebrated too early. I complained to the Medical Association's Arbitration Court, which overturned the ruling from the Ethical Council: "Psychiatrist Henrik Day Poulsen violated collegial rules for doctors and used 'unnecessarily offensive and derogatory' expressions in a *Berlingske* article and subsequent TV debate."[1001]

Two psychiatrists responded to Poulsen's ravings about my book in the article, *Corrupt and paranoid article*.[1002] Later that year, Poulsen said that "There is no risk if seriously ill patients in closed psychiatric wards receive antipsychotic medication in doses that are up to three times higher than the dose the authorities generally recommend."[1003] I believe Poulsen is so dangerous for his patients that his licence to practice should be withdrawn.

Psychiatry is a madhouse. But not so much because of the patients who are either not mad, or their madness is often temporary. In contrast, the madness of many psychiatrists is chronic, collective and incurable. Bob told me that a patient in an asylum once wrote: The psychiatrists called me mad, and I called them mad, and then they outvoted me.

That is the main problem. There are too many mad psychiatrists, and those who hold the power are the maddest.

12 Hopes for a better psychiatry

I have tried to change psychiatry from the inside, with no success. In January 2016, I had a meeting with three members of the board of the Danish Psychiatric Association, including the chair and co-chair, to discuss issues we agreed about and where we might support each other. For me, the most important issues were to help all those who wanted to come off their drugs but couldn't because they had become dependent on them, and to reduce the use of coercion.

The meeting went well, and I was invited to visit the closed wards where the two chairs worked, which I did. This was very interesting. During my first visit, I met with two patients whom I had met before, when they were out in the community.

However, I was not welcome when, in December 2017, I applied for membership of the Danish Psychiatric Association. This should have been appreciated because, according to their own rules:

"The aim of the Association is to further Danish psychiatry. In particular, it is a task of the Association to further Danish psychiatric research, to ensure the best possible education of psychiatrists, to work towards providing optimal psychiatric treatment for the population, and to propagate knowledge about psychiatry."

I explained that I had contributed to the aims of the Association over many years without being a member.

Total silence. I sent a reminder, but the silence continued. After two months of waiting, I wrote to the entire board. The chair, Torsten Bjørn Jacobsen, replied that I did not work to further the aims of the Association. That was all.

Next, I sent a letter noting that they had violated their own rules, and I explained in detail the many ways in which I, to an unusual degree, had contributed to the aims of the Association. I also mentioned that, during their last annual meeting, an honourable member held a speech where he underlined that the psychiatrists needed to communicate with me.

Jacobsen replied that, "The board has emphasised the content and nature of your authoring business over the years, which contains opinions and views on the psychiatric specialty which are not in harmony with the Association's aims. The Association is, of course, responsive to different attitudes within the specialty, though a basic element of membership of the Association must be that you respect the specialty and its accepted forms of treatment, which your authoring business does not live up to."

What a revelation! I knew it was unlikely that I would succeed, but by trying, I uncovered what psychiatrists really stand for, behind all the official window dressing. It's like touching a spider's tubular net to see it come rushing out of its hide in the bottom. This was censorship and obstructionism, which reflected what many psychiatrists in training had told me. You are in bad standing if you criticise the way your colleagues make diagnoses and overdose their patients.

During the Association's general assembly three months later, Kristian Sloth asked why I could not become a member. He got no meaningful reply, but the audience applauded nonetheless. As I was lecturing at the same hotel, offering two seminars about psychiatric drug withdrawal (see page 114), I had sneaked in and sat in the back of the room, hearing it all.

Three months later, the Association had a new chair, Gitte Ahle, and I applied again. To my point that no satisfactory explanation had been given at the general assembly, she

replied that, “We do not share this view because people were satisfied with the oral statement as to why you had been rejected.”

Interesting. Psychiatric patients are also told that what they have themselves observed is not correct because their psychiatrists do not share their views.

It felt a bit like when I went to Yellowstone with my family in 2006 and we flew into Salt Lake City. On a Sunday, there was church service in a Mormon church, and we wanted to participate out of curiosity to see what rituals this sect followed. When we were denied entrance, without the guards so much as asking if we were Mormons, I said: “I don’t understand this. Did Jesus not say, let the children come unto me, and that the church should be open to everyone?” That didn’t help. And the church of psychiatry is not for everyone – only for believers in the rituals.

Critical Psychiatry Network

I consider the Critical Psychiatry Network the most important hope for a better psychiatry. It was founded by a group of UK psychiatrists in 1999 to discuss changes to the Mental Health Act proposed at that time. Currently the group consists of over 400 members, two thirds of whom are based in the UK, the rest spread around the world.[1004]

Membership is limited to doctors working in psychiatry or related fields, but on the recommendation of Lisbeth Kortegaard, I was allowed to join in 2013. Sami Timimi told Lisbeth that I would be “a fantastic addition to the CPN. Do you think he might be interested in joining our Network?” I saw it the other way around: That it would be an honour for me to join this enlightened group.

Sami asked the secretary to add me to the membership, as I had “done some excellent analyses of psychiatric drug studies and the influence of the pharmaceutical industry.”

The network was founded by Joanna Moncrieff and Tom Stockmann, and its current chairs are Joanna and Hugh Middleton. In 2015, Denise Winn did an interesting interview with Hugh, *Time to rethink psychiatry*[1005] because he had published the book, *Psychiatry reconsidered: from medical treatment to supportive understanding*.”[1006]

Hugh says in the book that psychiatry’s core business is dealing with social phenomena, and when Denise asked him why we need a psychiatrist at the top, a medical person, when stress can lead to all sorts of symptoms and behaviours, such as anxiety, depression, anger outbursts, addictions and psychosis, he replied, “Perhaps we don’t.”

Hugh explains that a small number of people and the opinions they articulate have a disproportionate effect on the way resources are distributed, and that some psychiatrists have been formally disciplined for not giving antipsychotic agents as much as the psychiatric establishment expect.

Hugh notes that “a stark lesson from the last half century’s flirtation between psychiatry and biomedicine is that attempts to view and treat people who have difficulty living amongst others as ‘diseased’ are flawed ... biomedicine and other expressions of an ‘illness’ model do not offer an effective or acceptable alternative to doing the more difficult, but far more human and healing thing; understanding and reaching out to others in distress.”

Other progressive psychiatrists

After having read books by Bob Whitaker and me, 46-year-old chief physician Klaus Munkholm from the psychiatric department at Rigshospitalet, had realised that what he had believed in for so many years, was not correct. He contacted me in 2017 with his concerns that biological psychiatry had not been helpful for understanding psychiatric disorders, and he wanted to do meaningful research.

We met and started a fruitful research collaboration. But it had repercussions for Klaus. He was discouraged from collaborating with my research group and was warned that it would have consequences for his career.

I told him that this was like religious fanatism. Jehovah's Witnesses and Scientology treat defectors the same way, which was unheard of in an academic context but showed us a lot about where psychiatry is.

Klaus didn't budge, and, five months later, I employed him one day a week. He was a great asset for our projects, and a year after he contacted me, I employed him full-time. Some of psychiatry's silverbacks, who had previously held him in high regard, now treated him as a heretic.

Another chief psychiatrist, Kristian Sloth from Randers Hospital, also asked to meet with me in 2017. He said that Psychiatry in the Capital Region had announced that depression pills can prevent dementia, which is impossible, and research has shown it is more likely that psychiatric drugs *cause* dementia.[1007]

Kristian had reduced drug expenses by 35% in just one year after he started working at the department. One patient with schizophrenia who had received a high dose of clozapine (Leponex) became psychotic, got even more of the drug and ended up in a maximum-security ward. When they stopped Leponex, the psychotic symptoms disappeared.

Kristian opened a section in his department called "force-free department" where the patients are not coerced. Kristian and his colleague, Anders Lindelof, do something radically different from other psychiatrists.[1008] They do not focus on diagnoses and drugs. They focus on the person they are talking to and on the relationships that have often been broken for the patient, asking, "What happened in your life that brought you here?" They do not look for faults in the person but try to find the cause of the mental breakdown.

Their approach is based on the establishment of safe and stable relationships with the therapists. All staff on the ward talk to patients and are committed to building good relationships and having meaningful conversations with them about their lives, about what they want, and about what is important to them - instead of just saying, "Have you remembered to take your medicines?" and hurrying on to the next patient.

Kristian and Anders were so successful with this approach that they had available beds and said they didn't need more money. They wanted to tell their story to the management in the region but were not allowed to do so and sensed they were regarded as blacklegs. It was taboo to go against the eternal mantra in psychiatry, "Send more money."

Kristian and Anders listened to the lectures Anders Sørensen and I gave about drug withdrawal during the annual meeting of the Danish Psychiatric Association in 2018 (see page 114), and Kristian invited us to his hotel room afterwards for drinks. It was full of young psychiatrists, and some of them at first looked a little sceptical, but it wasn't long before they realised that we were not at all "dangerous" as they had been told by their bosses, but just wanted to contribute to creating a better psychiatry, like themselves.

Other psychiatrists have also seen the light. Clive Sherlock has a website, Adaptation Practice,[1009] where he explains that this is a unique, safe, and effective way to relieve emotional, psychological, and mental suffering – including depression, anxiety, anger, stress, eating disorders, and other related conditions – without drugs or talking therapies. He sees such conditions as natural, normal reactions to life, not as medical illnesses. Adaptation comes through practice, which has roots in the Far East.

Lee Combrinck-Graham, a retired psychiatrist, said that psychiatrists might ask: "What kind of psychiatrist are you, if you don't prescribe medicine?" And she would respond: "What kind of a psychiatrist are you if you don't talk to your patients, or, more specifically, listen to your patients and meet their family members or close associates, find out about them and include them in your ways of understanding what is going on? What kind of doctor are you if you don't look at development, adaptation, and the ups and downs in their lives?"

A third young psychiatrist who came to see me quit her job at Glostrup Hospital where chief psychiatrist Lars Søndergård had so greatly overdosed the patients, and against the guidelines, that he was fired and forbidden to work as a psychiatrist.[1010] She went to Slagelse Hospital, but Søndergård had been allowed to practice again, under close supervision, and he showed up there and continued to overdose his patients.

His boss, Michael Schmidt, failed to supervise him, and it was pure luck that he didn't kill any of his patients whom he often treated with several psychosis pills simultaneously.

Søndergård's malpractice included suspending the correct treatment of alcoholic delirium instituted by another doctor. He prescribed two psychosis pills to be taken together, but in such patients these drugs markedly increase the risk of convulsions, acute cardiac arrhythmias, and death.[1011] Another patient received methadone, which can cause lethal arrhythmias, and the Board of Health recommends against concomitant treatment with psychosis pills, but this patient was prescribed three psychosis pills simultaneously, in spite of which he was discharged the same day.

The nurses and Søndergård's psychiatrist colleagues were very concerned and contacted Schmidt, but nothing happened.[1012] As the culture at the department was one of fear and intimidation, the nurses involved their union.

Schmidt's reply to a journalist was extremely arrogant and showed that he was also dangerous for the patients.[1013] He could not "recognise" any of the horrible examples of overdosing the journalist sent to him.

It took four months for the Patient Safety Authority to respond to these concerns, even though patients might have been killed in the meantime. The verdict was harsh.[1014] Schmidt was placed under strict supervision and Søndergård could no longer work as a psychiatrist, at least not for a time.

Schmidt had approved a proposal from Søndergård that meant the patients became greatly overdosed, and he had been unable properly to interpret a scientific article from which he concluded the opposite of what the article said about dosage. Schmidt had also failed to inform the Authority of the excessive doses, even though it was his duty to do so, and the staff had made him aware of it several times.

Schmidt wrote to the Authority that Søndergård "has a sharp analytical approach" and had "brought the department to a higher professional level," contrary to the Authority's opinion that Søndergård in several cases had exposed the patients to serious danger.

Deputy Director Søren Bredkjær from the region issued a press release emphasising that they still had full confidence in Schmidt and that he had only received a mild sanction.

The young psychiatrist who contacted me had reported Schmidt to the Authority after having tried for months to solve the problems by taking them up with him. Schmidt's reaction was to label her "an insane cantankerous person" in front of colleagues.

Eventually, she gave up and went to Bredkjær whom she encouraged to examine the relevant patient files. She showed him a list of the patients who were admitted on a day she was on duty and let him see her personal notes. She asked him to investigate the matter, but when nothing happened, she saw no other option but to go to the press.

Bredkjær talked mumbo-jumbo to the journalist and refused to apologise to the nurses and doctors who had warned about the problems but had been ignored, also by himself.

What I have just described is in no way unique.

All the young psychiatrists who have come to see me have appreciated working with their patients. I told them they were exactly the type of doctors the patients needed, and that they should not leave psychiatry. One of them was seriously reprimanded by her boss when she began to slowly withdraw the drugs the patients didn't need, but which he had started in the outpatient facility.

Another psychiatrist wrote to me about his colleagues: "Can you imagine how it is to share coffee and lunch with these people, day in and day out?" He was forced to listen to their ramblings, and when he asked for the evidence, they became angry. Some always talked about colleagues who were bad at making diagnoses, but when he asked them how they knew they were correct, they became angry. "Worst of all, I need to listen to the lifestyle-oriented psychiatrists' talks about their apartments, cars, and travels, and they get angry with me if I even mention psychiatry. What I have painfully learnt about these people is that most of them are completely uninterested in reading the actual articles about the clinical trials we have. Instead, they simply follow their leader."

Please pause for a moment. These are the people who are supposed to take care of our most vulnerable citizens, and they are allowed to use force. This tells us that we should abolish psychiatry and start from scratch. When a house is totally rotten, it won't help to try and repair it. We need to tear it down and build a new one.

In 2018, Joakim Börjesson, who did research with me on lithium in 2017 (see page 84), arranged a debate in Göteborg during the annual conference for 150 Swedish psychiatrists in training between clinical pharmacologist, Professor Elias Eriksson, and me about SSRIs.[1015]

Joakim had needed his diplomatic skills to arrange this debate, and especially to deal with Eriksson who has a reputation for attacking his opponents violently. He told Joakim that he intended to reveal that I was a charlatan. Joakim discussed this with him for about an hour and "fruitlessly tried to convince him to adhere to the rules for the debate."

Eriksson was horrible. He claimed in his abstract that the pills don't cause irreversible side effects; that they are not addictive; that criticisms are ideologically founded; and that their use according to the critics was the result of a worldwide conspiracy that included psychiatrists, researchers, authorities, and drug companies.

When I debated with Eriksson on Swedish radio five months earlier, he had also lied, saying the pills help dramatically and can prevent suicide.[1016]

What is typical for debates with people who try to defend a sick system also happened this time. Eriksson broke the rules, lied, and used dirty tricks to try and convince the audience that I could not be trusted. I mentioned that he had entered a secret agreement with Lundbeck against his university's rules, which meant that Lundbeck could prevent

publication of his research if they didn't like the results.[1017] I said this because Eriksson routinely "forgets" to declare his conflicts of interest, but I was immediately stopped by the chair.

Later, the Ombudsman criticised the university for covering up the affair.[1018] Eriksson claimed he could not provide his correspondence with Lundbeck to a journalist because it had taken place on a Lundbeck server. If true, this was a highly unusual arrangement, and he lied about what a Freedom of Information request had addressed.

After the meeting, a psychiatrist wrote to me that you cannot convince religious people that there is no evidence for God's existence, but you can make them lose confidence in their priest if you can show evidence that he has used church donations to buy cocaine in a gay bar. He noted that, "Eriksson is a simple lobbyist who has made a fortune by playing political games rather than doing honest research, and he knows this himself. That is why he can lie about things he very well knows are untrue."

Joakim was unhappy that many of the psychiatrists had not understood my explanations about depression pills causing suicide. But when I present the same slides for a lay audience, they *always* understand them. The psychiatrists *don't want* to understand what is too painful for them. It was already too late to try to influence these young psychiatrists in training.

Seven years earlier, Bob Whitaker was speaking at a meeting in Malmö that child psychiatrists had arranged, but other psychiatrists intervened and got control of the meeting. Bob was forbidden to present any data on long-term outcomes of drug treatment. He went along with it, but when he arrived, he was told that Eriksson would be his opponent. Eriksson spent his time denouncing Bob in a dishonest fashion. In Bob's own words: "The whole thing was a disgusting setup that stands out for its complete dishonesty, from start to finish." Eriksson declared that Bob was a "charlatan who tortures patients."

I had planned on attending, but Eriksson said he would not participate if I came!

It is strange how psychiatry's apologists constantly call their opponents names and use strawman arguments. None of us has ever said anything about a conspiracy, and psychiatrists have no need to conspire. All they need to do is selfishly work in pursuit of their own self-interest, which may give the appearance of conspiring.

A new paradigm is needed for psychiatry

In 2023, I explained in an article on the Mad in America website with 100 references why we need a new paradigm for testing psychiatric drugs.[1019] The universal use of short-term placebo-controlled trials with ineffective blinding, subjective outcomes assessed on rating scales with dubious clinical relevance, exposure of patients in the placebo group to drug withdrawal effects, and the reporting of results selectively has produced a literature plagued with misleading results that has resulted in tremendous harm for the patients.

I showed the draft article to Maryanne Demasi and Bob Whitaker who found it excellent. But when I submitted it to medical journals, the comments were so bizarre that I published another article, too: *How peer reviewers and editors protected a failed paradigm for psychiatric drug testing*.[1020]

None of the editors allowed me to challenge their sacred cow - the prevailing paradigm. Many comments were irrelevant or false, e.g. that drugs improve cognition; that psychiatric disorders are caused by a chemical imbalance; and that patients in schizophrenia trials are not exposed to a cold turkey because they have not received neuroleptics before. I was also

told that I "undermined the vast scientific evidence of the beneficial effects of psychotropic drugs." But that was exactly why my article was important!

My article was not rejected because I didn't know how to write good articles. I am the only Dane who has published over 100 articles in "the big five" (*BMJ*, *Lancet*, *JAMA*, *Annals of Internal Medicine* and *New England Journal of Medicine*) and my scientific works have been cited over 150,000 times.

I argued that, in future, trials of psychiatric drugs should include only treatment-naïve patients; use psychotherapy or other psychosocial interventions as the comparator; use no rating scales, as they are not meaningful; use patient-relevant outcomes, e.g. returning to a normal productive life; focus on drug harms; have a follow-up over several years; be planned and conducted by people with no conflicts of interest; and provide easy access to anonymised raw data so that others can check the veracity of what is claimed.

The titles of Bob's two famous books say it all about what is wrong with psychiatry: *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill*,[1021] and *Anatomy of an epidemic: magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*.[1022] In the very first review of Bob's second book, the reviewer accused him of doing great harm with the book, likening him to a South African dictator who by virtue of denying AIDS had caused hundreds of thousands of people to die.[1023] After that review ran, Bob had radio interviews cancelled, and no other major newspaper reviewed the book.

The psychiatric drug epidemic is likely the most harmful epidemic we have. It's even worse than our obesity epidemic, which doesn't change our brains and doesn't make some people so mad that they kill themselves or others.

Psychiatrists have degenerated into being drug pushers for Big Pharma, whose business model is organised crime. They persuade people to take drugs that will harm them, just like street pushers do with narcotics.

The time for diplomacy, with gentle suggestions of much-needed reforms in psychiatry, is over. This has been tried many times and it has led nowhere. In fact, psychiatry has worsened and is harming and killing more people than ever before because drug usage goes up all the time.

Revolutions don't come from people at the top of the power pyramid who benefit from the harmful status quo. The only hope we have is if patients, their relatives, and the public protest so that we get the necessary support from our politicians to start an unstoppable revolution.

It means a lot for victims of abuse to get an apology. For a start, the psychiatric leaders should apologise for the immense harm they have inflicted on the patients by lying systematically to them. If they are unwilling to do this, governments should demand that psychiatric associations apologise unconditionally to the public as a condition for their continued support of this specialty.

Mental health issues are not medical issues. They should not be handled by psychiatrists, as they have a medical education, but by the caring professions and recovery mentors who have lived experience with surviving psychiatry and getting rid of psychiatric drugs. It is long overdue that psychiatry as a medical specialty gets disbanded. In evidence-based healthcare, we don't use interventions that do more harm than good, which psychiatry does.

Psychiatrists should be re-educated so that they can provide psychotherapy and other psychosocial interventions. Those who are not willing to do this should quit, retire early, or be fired. Psychiatry is a crime against humanity and there should be penalties, including jail

sentences in severe cases, for propagating false information or for drugging patients against their will if it results in death or permanent functional impairment.

The diagnostic systems, DSM-5 and ICD-11, should be discarded as they are arbitrary, unscientific, and harmful. We need to start over again and make it simple, focusing on the patients' problems rather than giving them one or more labels that will stick to them forever. Formal diagnoses are not useless, but they should be simple and not of the current type: Find x faults out of y, or use some arbitrary scores.

NIMH has abandoned the use of the DSM as a research tool, and in 2013, its president, Thomas Insel, explained why:[1024]

"Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure. In the rest of medicine, this would be equivalent to creating diagnostic systems based on the nature of chest pain or the quality of fever."

The main focus in future should be on helping the hundreds of millions of patients who have become dependent on psychiatric drugs, to withdraw slowly and safely from them, instead of telling them that they need to get on them and to stay on them. We will need 24-hour national helplines, associated websites, and drug withdrawal centres that provide free advice and support.

American emeritus professor of psychiatry and chairman of the DSM-III committee, Allen Frances, has stated that psychoactive drugs should not be prescribed by family physicians because they lack experience in their use.[1025] I agree. Not even psychiatrists can handle them prudently. The chair for the Danish Association for General Practitioners said in 2014 about depression, that they didn't have "oceans of time" and couldn't set aside a whole hour for one patient, as they also needed to think of their economy.[1026] They therefore hand out depression pills liberally. This must stop.

Most psychiatric drugs should be removed from the market, as their availability clearly does more harm than good. Psychiatric drugs should only be allowed for rare use under strictly controlled circumstances, e.g. in acute situations; while patients are tapering off them; when it is impossible to taper off them because they have caused permanent brain damage; in alcoholic delirium; and as sedatives during invasive procedures.

Forced treatment must be made unlawful, as it can be lethal and is discriminating and unethical, and all rules about demanding a psychiatric diagnosis to get social benefits, or extra economic support to schools, must be removed.

It will be a tough battle. Psychiatry's focus is on itself - a kind of false selfie it sends to the world all the time - is about what will make life as a psychiatrist endurable. It should be about what will make the patients' lives endurable.

While the battle goes on, we will need constantly to tell the public that it is rarely a good idea to see a family doctor or a psychiatrist if they have a mental health issue, since there is a huge risk they will be harmed.

Having the last laugh at psychiatry

It is easy to convince healthy people to take drugs they don't need for a disease they don't have. The Australian artist, Justine Cooper, invented a hilarious hoax.[1027] It looks like a TV commercial and advertises Havidol ("have it all"), with the chemical name avafynetyme HCl. Havidol is good for those who suffer from dysphoric social attention consumption deficit anxiety disorder (DSACDAD). Feel empty after a full day of shopping? Enjoy new things more

than old ones? Does life seem better when you have more than others? Then you may have the disorder, which more than 50% of adults have.

Havidol should be taken indefinitely. Side effects include extraordinary thinking, dermal gloss, markedly delayed sexual climax, interspecies communication, and terminal smile. "Talk to your doctor about Havidol."

Some people believed it was for real and added it to websites for panic and anxiety disorder, or for depression.

An even more hilarious video featured Australian journalist Ray Moynihan as a victim.[1028] It's about an epidemic – motivational deficiency disorder. In its mild form, people cannot get off the beach, or out of bed in the morning, and in its most severe form it can be lethal as the sufferer may lose the motivation to breathe.

Moynihan says that, "All my life people have called me lazy. But now I know I was sick." The drug is Indolebant, and its champion, neuroscientist Leth Argos, reports how a patient's wife telephoned him and was in tears. She said that after using Indolebant, her husband had mowed the lawn, repaired the gutter, and paid an electricity bill – all in one week. Although Moynihan described the new disorder in the *BMJ's* 1 April issue in 2006, [1029] some people believed it was a true disease and asked where they could buy Indolebant.

These satires come close to ads on American TV about psychiatric drugs. I showed them as an introduction to my talk about overdiagnosis and overtreatment when I lectured for over 100 psychiatrists in 2016. They laughed out loud but not when I added that what they had just seen wasn't far from their everyday practice. But we had a good discussion afterwards.

Documentaries and filmed interviews

Sometimes, the written word can accomplish much needed changes. But most of the time, it doesn't. Documentaries and filmed interviews can be much more powerful and can reach many more people, which is why I started to collaborate closely with one of Denmark's best documentary filmmakers, historian Janus Bang from Fredericia, in 2023.

We launched an evidence-based film series, *Broken Medical Science*, in September 2023, which quickly gained momentum.

Our main focus is psychiatry because it is second to none in harming people. We went on a 12-day tour to the USA in November 2023 and to London in April 2024, and many of the people I interviewed have a deep insight into psychiatry: Huey Freeman, Kim Witczak, Michael Baum, Jim Gottstein, Nancy Rubenstein, Wendy Dolin, John Read, Katinka Blackford Newman, Sami Timimi, and Joanna Moncrieff. The trips resulted in over 20 hours of raw film in cinema quality. Previously, we uploaded interviews with Joanna Moncrieff and Mark Horowitz.

It is easy to subscribe to our newsletter,[1030] and we very much hope people will help us and the patients and their relatives by spreading our messages widely. Financial support would also be most welcome.[1031] We work *con amore* and use our own money for our activities, in addition to the money people donate to us. Our first documentary film will be *The honest professor and the fall of the Cochrane empire*.

About the author

I graduated as a Master of Science in biology and chemistry in 1974 and as a physician in 1984. I am a specialist in internal medicine, worked with clinical trials and regulatory affairs in the drug industry 1975-1983, and at hospitals in Copenhagen 1984-95.

I co-founded the Cochrane Collaboration and established the Nordic Cochrane Centre in 1993, became professor of Clinical Research Design and Analysis in 2010 at the University of Copenhagen, co-founded Council for Evidence-based Psychiatry in the UK in 2014 and the International Institute for Psychiatric Drug Withdrawal in Sweden in 2016, and founded the Institute for Scientific Freedom in 2019.

I am officially retired but continue my scientific work and I also work as an independent consultant, for example in lawsuits, and as a filmmaker.

My greatest contribution to public health was when I opened the archives in the European Medicines Agency in 2010 and got access to the clinical study reports of drugs after a three-year long battle that involved a complaint to the European Ombudsman. The agency was solely concerned with protecting the drug industry's interests while ignoring those of the patients.

I have published over 100 papers in "the big five" (*BMJ*, *Lancet*, *JAMA*, *Annals of Internal Medicine* and *New England Journal of Medicine*) and my scientific works have been cited over 150,000 times. My H-index is 91 (Web of Science, June 2023), which means that 91 of my papers have been cited at least 91 times. I am author of several books, including:

Critical psychiatry textbook (2022). Freely available.
The Chinese virus: Killed millions and scientific freedom (2022). Freely available.
Mental health survival kit and withdrawal from psychiatric drugs: a user's guide (2022, in 7 languages).
The decline and fall of the Cochrane empire (2022). Freely available.
Vaccines: truth, lies and controversy (2021, in 7 languages).
Survival in an overmedicated world: Find the evidence yourself (2019, in 7 languages).
Death of a whistleblower and Cochrane's moral collapse (2019).
Deadly psychiatry and organised denial (2015, in 9 languages).
Deadly medicines and organised crime: How big pharma has corrupted health care (2013, in 18 languages). Winner, British Medical Association's Annual Book Award, Basis of Medicine, in 2014.
Mammography screening: truth, lies and controversy (2012). Winner of the Prescrire Prize in 2012.
Rational diagnosis and treatment: evidence-based clinical decision-making (2007).

I have given numerous interviews, one of which - about organised crime in the drug industry - has been seen by half a million on YouTube.[1032] I was in The Daily Show in New York on 16 Sept 2014 where I played the role of Deep Throat revealing secrets about big pharma.[1033]

A documentary film about my reform work in psychiatry, *Diagnosing Psychiatry*, appeared in 2017,[1034] and another one, *The honest professor and the fall of the Cochrane empire*, about my life and the moral collapse of the Cochrane Collaboration, is in preparation; donations to the film can be given via the link.[1035]

I have an interest in statistics and research methodology and have co-authored guidelines for good reporting: CONSORT for randomised trials, STROBE for observational studies, PRISMA for

systematic reviews and meta-analyses, and SPIRIT for trial protocols. I was an editor in the Cochrane Methodology Review Group 1997–2014.

I am Protector for the Hearing Voices Network in Denmark.

Peter C Gøtzsche, Professor emeritus and Director
Websites: scientificfreedom.dk and deadlymedicines.dk.
Twitter: @PGtzsche1
Email: pcg@scientificfreedom.dk
Films and podcasts: Broken Medical Science

Endnotes

[1] Shifting the balance towards social interventions: a call for an overhaul of the mental health system. Beyond Pills All-Party Parliamentary Group 2024;May.
[2] Shifting the balance towards social interventions: a call for an overhaul of the mental health system. Beyond Pills All-Party Parliamentary Group 2024;May.
[3] Heskestad, Stig, et al. (2019). Medikamentfri psykiatrisk behandling – hva mener pasientene? Tidsskr Nor Legeforen 139. doi: 10.4045/tidsskr.18.0912.
[4] United Nations Convention on the Rights of Persons with Disabilities: General comment No. 1. 2014;May 19.
[5] Council of Europe. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). CPT/Inf/E (2002) 1 - Rev. 2013.
[6] Gøtzsche PC. Deadly medicines and organised crime: How big pharma has corrupted health care. London: Radcliffe Publishing; 2013; Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015; Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022; Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022 (freely available).
[7] Crimes against humanity. Trial International.
[8] Gøtzsche PC. Prescription drugs are the leading cause of death. And psychiatric drugs are the third leading cause of death. Mad in America 2024;April 16.
[9] Hubbard R, Farrington P, Smith C, et al. Exposure to tricyclic and selective serotonin reuptake inhibitor antidepressants and the risk of hip fracture. Am J Epidemiol 2003;158:77-84 and Thapa PB, Gideon P, Cost TW, et al. Antidepressants and the risk of falls among nursing home residents. N Engl J Med 1998;339:875-82; Khanassov V, Hu J, Reeves D, van Marwijk H. Selective serotonin reuptake inhibitor and selective serotonin and norepinephrine reuptake inhibitor use and risk of fractures in adults: A systematic review and meta-analysis. Int J Geriatr Psychiatry 2018;33:1688-1708.
[10] Healy D. Medical partisans? Why doctors need conflicting interests. Aust N Z J Psychiatry 2012;46:704–7.
[11] Association of Certified Fraud Examiners. Fraud 101: What Is Fraud? (accessed 3 Jan 2024).
[12] Breggin P. The most dangerous thing you will ever do. Mad in America 2020;March 2.
[13] Gøtzsche PC. Survival in an overmedicated world: look up the evidence yourself. Copenhagen: People's Press; 2019.
[14] Nielsen M, Hansen EH, Gøtzsche PC. What is the difference between dependence and withdrawal reactions? A comparison of benzodiazepines and selective serotonin re-uptake inhibitors. Addiction 2012;107:900–8.
[15] Korsgaard P, Jensen JH. [Drug maker: nonsense! Denies dependence on happy pills: It isn't possible]. Ekstra Bladet 2012;Dec 11.
[16] Demasi M, Gøtzsche PC. Presentation of benefits and harms of antidepressants on websites: cross sectional study. Int J Risk Saf Med 2020;31:53-65.
[17] Priest RG, Vize C, Roberts A, et al. Lay people's attitudes to treatment of depression: results of opinion poll for Defeat Depression Campaign just before its launch. BMJ 1996;313:858-9.
[18] Davies J, Read J. A systematic review into the incidence, severity and duration of antidepressant withdrawal effects: Are guidelines evidence-based? Addict Behav 2019;97:111-21.
[19] Nielsen M, Gøtzsche P. An analysis of psychotropic drug sales. Increasing sales of selective serotonin reuptake inhibitors are closely related to number of products. Int J Risk Saf Med 2011;23:125–32.
[20] Gøtzsche PC, Dinnage O. What have antidepressants been tested for? A systematic review. Int J Risk Saf Med 2020;31:157-63.
[21] Petersen M. Our daily meds. New York: Sarah Crichton Books; 2008 and Larson JC, Ensrud KE, Reed SD, et al. Efficacy of escitalopram for hot flashes in healthy menopausal women: a randomized controlled trial. JAMA 2011;305:267–74.
[22] Whitaker R. Mad in America: bad science, bad medicine, and the enduring mistreatment of the mentally ill. Cambridge: Perseus Books Group; 2002.
[23] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015.
[24] Moore J. Robert Whitaker answers reader questions on Mad in America, the biopsychosocial model, and psychiatric history. Mad in America 2023;Dec 13.
[25] Healy D. Let them eat Prozac. New York: New York University Press; 2004; Moncrieff J. The myth of the chemical cure: a critique of psychiatric drug treatment. Basingstoke: Palgrave Macmillan; 2007; Breggin PR. Brain-disabling treatments in psychiatry: drugs, electroshock, and the psychopharmaceutical complex. New York: Springer; 2008; Moncrieff J. The bitterest pills. Basingstoke: Palgrave Macmillan; 2013; Newman KB. The

pill that steals lives. London: John Blake; 2016; Gottstein J. The Zyprexa papers. Anchorage: Jim Gottstein; 2020; Timimi S. Insane medicine: How the mental health industry creates damaging treatment traps and how you can escape them. Seattle: Kindle Direct Publishing; 2021.

[26] Angell M. "The illusions of psychiatry": an exchange. New York Rev Books 2011;Aug 18.

[27] Angell M. Is academic medicine for sale? N Engl J Med. 2000; 342: 1516–8 and Angell M. The Truth about the Drug Companies: how they deceive us and what to do about it. New York: Random House; 2004.

[28] More fraud from drug giant GlaxoSmithKline companies – court documents show. Child Health Safety 2010;Dec 1.

[29] Keller MB, McCullough JP, Klein DN et al. A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression. N Engl J Med 2000;342:1462-70.

[30] Angell M. Is academic medicine for sale? N Engl J Med 2000; 342:1516-8.

[31] Transforming mad science and reimagining mental health care. Lectures. Los Angeles 2014;Nov 15.

[32] Gøtzsche PC. Origin of COVID-19: The biggest cover up in medical history. Brownstone Institute 2023; Oct 9 and Gøtzsche PC. The Chinese virus: Killed millions and scientific freedom. Copenhagen: Institute for Scientific Freedom; 2022. Freely available.

[33] McLaren N. Anxiety, the inside story. How biological psychiatry got it wrong. Ann Arbor: Future Psychiatry Press; 2018.

[34] Kingdon D, Young A. Research into putative biological mechanisms of mental disorders has been of no value to clinical psychiatry. Br J Psychiatry 2007;191:285–90.

[35] Kleinman A. Rebalancing academic psychiatry: why it needs to happen – and soon. Br J Psychiatry 2012;201:421–2.

[36] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 227.

[37] Breggin P. Medication madness. New York: St. Martin's Griffin; 2008.

[38] Kirk SA, Gomory T, Cohen D. Mad science: psychiatric coercion, diagnosis and drugs. New Brunswick: Transaction Publishers; 2013.

[39]Whitaker R. Anatomy of an Epidemic, 2nd edition. New York: Broadway Paperbacks; 2015, page 8.

[40] Mors O, Nordentoft M, Hageman I (red.). Klinisk psykiatri. København: Munksgaard; 2016; Simonsen E, Møhl B (red.). Grundbog i psykiatri. København: Hans Reitzels Forlag; 2017; Videbech P, Kjølbye M, Sørensen T, Vestergaard P (red.). Psykiatri. En lærebog om voksnes psykiske sygdomme. København: FADL's Forlag; 2018; Thomsen PH, Rask CU, Bilenberg N (red.). Børne- og ungdomspsykiatri. København: FADLs Forlag; 2019; Starrfelt R, Gerlach C, Gade A (red.). Klinisk neuropsykologi. København: Frydenlund; 2021.

[41] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022 (freely available)

[42] Gøtzsche PC. Critical psychiatry textbook. Mad in America 2023.

[43] Federn T. Book review: Critical psychiatry textbook. Psychosis 2022;15:117-9.

[44] Simonsen E, Møhl B (red.). Grundbog i psykiatri. København: Hans Reitzels Forlag; 2017, page 645.

[45] Videbech P, Kjølbye M, Sørensen T, Vestergaard P (red.). Psykiatri. En lærebog om voksnes psykiske sygdomme. København: FADL's Forlag; 2018, pages 232 and 307.

[46] Caplan PJ. They say you're crazy: how the world's most powerful psychiatrists decide who's normal. Jackson: Da Capo Press; 1995.

[47] Kessler RC, Demler O, Frank RG, et al. Prevalence and treatment of mental disorders, 1990 to 2003. N Engl J Med 2005;352:2515–23.

[48] Spence D. The psychiatric oligarchs who medicalise normality. BMJ 2012;344:e3135.

[49] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015.

[50] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022 (freely available).

[51] Read J, Moncrieff J. Depression: why drugs and electricity are not the answer. Psychological Medicine 2022;Febr 1:1–10.

[52] Timimi S. Insane medicine: How the mental health industry creates damaging treatment traps and how you can escape them. Seattle: Kindle Direct Publishing; 2021, page 14.

[53] Kajanoja J, Valtonen J. A descriptive diagnosis or a causal explanation? Accuracy of depictions of depression on authoritative health organization websites. Psychopathology 2024;Jun 12:1-10.

[54] Dowrick C, Frances A. Medicalising unhappiness: new classification of depression risks more patients being put on drug treatment from which they will not benefit. BMJ 2013;347:f7140.

[55] Optimal health in a happy society: towards a new biomedical and social model. Global-Well 2022;May 5.
[56] Read J, Moncrieff J. Depression: why drugs and electricity are not the answer. Psychological Medicine 2022;Febr 1:1–10.
[57] Mental health, human rights and legislation: guidance and practice. WHO 2023;Oct 9, page xvii.
[58] Gøtzsche PC. Rational diagnosis and treatment. evidence-based clinical decision-making, 4th edition. Chichester: Wiley; 2007.
[59] Henkel V, Mergl R, Kohnen R, et al. Identifying depression in primary care: a comparison of different methods in a prospective cohort study. BMJ 2003;326:200-1 and Lundh A. Er der evidens for screening for depression? Ugeskr Læger 2008;170:1479.
[60] Schmidt AL. "Jeg har fået patienter indlagt, som stoppede med medicin og forsøgte selvmord på grund af den debat, der kørte." Politiken 2015;Sept 5.
[61] Gøtzsche PC. Skemaer for depression. Politiken 2015;Sept 8:6.
[62] Felsby O. En million danskere skal screenes for depression. Dagens Medicin 2008;March 7.
[63] Frances A. Saving normal. New York: Harper Collins; 2013.
[64] Gilbody S, House A, Sheldon T. Screening and case finding instruments for depression. Cochrane Database Syst Rev 2005;4:CD002792.
[65] Referenceprogram for unipolar depression hos voksne. København: Sundhedsstyrelsen; 2007.
[66] Gøtzsche PC. SSRI kan føre til selvmord. Dagens Medicin 2013;May 3.
[67] Kirk SA, Kutchins H. The selling of DSM: the rhetoric of science in psychiatry. New York: Aldine de Gruyter; 1992.
[68] Williams JB, Gibbon M, First MB, et al. The Structured Clinical Interview for DSM-III-R (SCID). II. Multisite test-retest reliability. Arch Gen Psychiatry 1992;49:630-6.
[69] Gøtzsche PC. Rational Diagnosis and Treatment. Evidence-Based Clinical Decision-Making, 4th edition. Chichester: Wiley; 2007, page 23.
[70] Greenberg G. The rats of NIMH. The New Yorker 2013;May 16; Hyman SE. The diagnosis of mental disorders: the problem of reification. Annu Rev Clin Psychol 2010;6:155-79; Allen Frances tweet. 2019;July 29.
[71] Belluck P, Carey B. Psychiatry's guide is out of touch with science, experts say. New York Times 2013;May 6.
[72] Pedersen AT. En psykiatrisk diagnose hænger ved resten af livet. PsykiatriAvisen 2019;Jan 18 and Frandsen P. Et anker af flamingo: Det, vi glemmer, gemmer vi i hjertet. Odense: Mellemgaard; 2019.
[73] McLaren N. Anxiety, the inside story. How biological psychiatry got it wrong. Ann Arbor: Future Psychiatry Press; 2018.
[74] Gøtzsche PC. Self-test for Adult Symptom Deficiency Disorder (ASDD). Mad in America 2023;April 26.
[75] Whitaker R. Putting JAMA Psychiatry and MIA to the genetic test. Mad in America 2024;Mar 13.
[76] Moncrieff J, Cooper RE, Stockmann T, et al. The serotonin theory of depression: a systematic umbrella review of the evidence. Mol Psychiatry 2023;28:3243-56.
[77] Moncrieff J, Cooper RE, Stockmann T, et al. Difficult lives explain depression better than broken brains. Mol Psychiatry 2024;Feb 19.
[78] Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022.
[79] Kessing L, Hansen HV, Demyttenaere K, et al. Depressive and bipolar disorders: patients' attitudes and beliefs towards depression and antidepressants. Psychological Medicine 2005;35:1205-13.
[80] France CM, Lysaker PH, Robinson RP. The "chemical imbalance" explanation for depression: origins, lay endorsement, and clinical implications. Professional Psychology: Research and Practice 2007;38:411-20.
[81] Whitaker R. Ronald Pies doubles down (and why we should care). Mad in America 2015;Sept 21.
[82] Sterll B. Den psykiatriske epidemi. Psykolognyt 2013;20:8-11.
[83] Varese F, Smeets F, Drukker M, et al. Childhood adversities increase the risk of psychosis: a meta-analysis of patient-control, prospective- and cross-sectional cohort studies. Schizophr Bull 2012;38:661-71 and Shevlin M, Houston JE, Dorahy MJ, Adamson G. Cumulative traumas and psychosis: an analysis of the national comorbidity survey and the British Psychiatric Morbidity Survey. Schizophr Bull 2008;34:193-9.
[84] Gøtzsche PC. Psychopharmacology is not evidence-based medicine. In: James D (ed.). The sedated society. The causes and harms of our psychiatric drug epidemic. London: Palgrave Macmillan; 2017.
[85] Ditzel EE. Psykiatri-professor om DR-historier: "Skræmmekampagne der kan koste liv." Journalisten 2013;Apr 11.
[86] Rasmussen LI. "Gøtzsche driver pointerne helt ud i det absurde." Ugeskr Læger 2014;176:120-1.

[87] Rasmussen LI. Industriens markedsføring er meget, meget effektiv. Den har fået lægerne til at tro på, at eksempelvis antidepressiva er effektive lægemidler. Det er de overhovedet ikke. Politiken 2015;Aug 30:PS 8-9 and Rasmussen LI. Dansk psykiatris onde ånd er tilbage. Politiken 2015;Aug 30:4.
[88] Gøtzsche PC. Tre psykiatriprofessorer på afveje. Politiken 2015;Sept 4 and Deadly Medicines 2015;Sept 5.
[89] Gøtzsche PC. Fup og fakta om psykofarmaka. Deadly Medicines 2015;Feb 16.
[90] Gøtzsche PC. Psykiatri på afveje. Politikens kronik 2014;Jan 6 and Gøtzsche PC. Psychiatry gone astray. Mad in America 2014;Jan 28.
[91] Kessing L, Hansen HV, Demyttenaere K, et al. Depressive and bipolar disorders: patients' attitudes and beliefs towards depression and antidepressants. Psychological Medicine 2005;35:1205-13.
[92] Rasmussen LI. Industriens markedsføring er meget, meget effektiv. Den har fået lægerne til at tro på, at eksempelvis antidepressiva er effektive lægemidler. Det er de overhovedet ikke. Politiken 2015;Aug 30:PS 8-9.
[93] Schultz J. Peter Gøtzsche melder psykiater til Lægeetisk Nævn. Dagens Medicin 2015;Oct 2 (Søndergård published an electronic comment to this article).
[94] Hyman SE, Nestler EJ. Initiation and adaptation: a paradigm for understanding psychotropic drug action. Am J Psychiatry 1996;153:151-62.
[95] Depression er en folkesygdom - især for kvinder. Psykiatrifonden 2017;Jan 31.
[96] Videbech P. SSRI, antidepressivum. Patienthåndbogen 2015;July 23 and Kessing LV. Depression, hvordan virker medicin. Patienthåndbogen 2015;July 5.
[97] Alvorlige fejl til skade og fare for patienterne … Deadly Medicines 2017;Feb 3, Feb 27, May 12 and June 13.
[98] Breggin PR. Brain-disabling treatments in psychiatry: drugs, electroshock, and the psychopharmaceutical complex. New York: Springer; 2008.
[99] Demasi M, Gøtzsche PC. Presentation of benefits and harms of antidepressants on websites: cross sectional study. Int J Risk Saf Med 2020;31:53-65.
[100] Psykiatrien i Region Midtjylland. Updated December 2021, February 2018, March 2022, January 2022, March 2022.
[101] Ditlevsen JV, Gøtzsche PC, Lassen M, et al. Det psykiatriske system er bygget på misinformation, som myndighederne formidler. Information 2022;Nov 17.
[102] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015, page 331.
[103] Schopenhauer A. The art of always being right. London: Gibson Square; 2009.
[104] Ang B, Horowitz M, Moncrieff J. Is the chemical imbalance an 'urban legend'? An exploration of the status of the serotonin theory of depression in the scientific literature. SSM Mental Health 2022;2:100098.
[105] Brody DJ, Gu Q. Antidepressant use among adults: United States, 2015-2018. CDC 2020:Sept.
[106] Whitaker R, Cosgrove L. Psychiatry under the influence: institutional corruption, social injury, and prescriptions for reform. New York: Palgrave Macmillan; 2015.
[107] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015, page 290.
[108] Laughren TP. Overview for December 13 Meeting of Psychopharmacologic Drugs Advisory Committee (PDAC). FDA 2006;Nov 16.
[109] Gøtzsche PC. Prescription drugs are the leading cause of death. And psychiatric drugs are the third leading cause of death. Mad in America 2024;April 16.
[110] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015, page 287.
[111] Priest RG, Vize C, Roberts A, et al. Lay people's attitudes to treatment of depression: results of opinion poll for Defeat Depression Campaign just before its launch. BMJ 1996;313:858-9 and Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022, page 1.
[112] Montejo A, Llorca G, Izquierdo J, et al. Incidence of sexual dysfunction associated with antidepressant agents: a prospective multicenter study of 1022 outpatients. Spanish Working Group for the study of psychotropic-related sexual dysfunction. J Clin Psychiatry 2001;62 (suppl 3):10–21.
[113] Gøtzsche PC. Vores lykkepille-epidemi er dybt skadelig. Berlingskes kronik 2012;Dec 16.
[114] Healy D, Le Noury J, Mangin D. Enduring sexual dysfunction after treatment with antidepressants, 5α-reductase inhibitors and isotretinoin: 300 cases. Int J Risk Saf Med 2018;29:125-34; Healy D, Le Noury J, Mangin D. Post-SSRI sexual dysfunction: Patient experiences of engagement with healthcare professionals. Int J Risk Saf Med 2019;30:167-78; Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022, page 170.
[115] Maciag D, Simpson KL, Coppinger D, et al. Neonatal antidepressant exposure has lasting effects on behavior and serotonin circuitry. Neuropsychopharmacology 2006;31:47–57.

[116] Simonsen AL, Danborg PB, Gøtzsche PC. Persistent sexual dysfunction after early exposure to SSRIs: Systematic review of animal studies. Int J Risk Saf Med 2016;28:1-12.
[117] Danborg PB, Valdersdorf M, Gøtzsche PC. Long-term harms from previous use of selective serotonin reuptake inhibitors: A systematic review. Int J Risk Saf Med 2019;30:59-71.
[118] Moncrieff J, Cohen D. Do antidepressants cure or create abnormal brain states? PLoS Med 2006;3:e240.
[119] Cipriani A, Zhou X, Del Giovane C, et al. Comparative efficacy and tolerability of antidepressants for major depressive disorder in children and adolescents: a network meta-analysis. Lancet 2016;388:881-90 and Jakobsen JC, Katakam KK, Schou A, et al. Selective serotonin reuptake inhibitors versus placebo in patients with major depressive disorder. A systematic review with meta-analysis and Trial Sequential Analysis. BMC Psychiatry 2017;17:58. (In the clinical study reports of depression pills I obtained from the European Medicines Agency, the median standard deviation on the Hamilton scale after treatment was 7.5. Thus, an effect size of 0.25 corresponds to 2 on the Hamilton scale).
[120] Leucht S, Fennema H, Engel R, et al. What does the HAMD mean? J Affect Disord 2013;148:243-8.
[121] Jakobsen JC, Katakam KK, Schou A, et al. Selective serotonin reuptake inhibitors versus placebo in patients with major depressive disorder. A systematic review with meta-analysis and Trial Sequential Analysis. BMC Psychiatry 2017;17:58.
[122] Gøtzsche PC. Depressionspiller gør større skade end gavn. Berlingske, Dagens Brev 2017;June 25.
[123] Jørgensen KJ, Gøtzsche PC. Arbejder Lægemiddelstyrelsen for patienterne? Politikens Kronik 2018;Feb 5.
[124] Spørgsmål nr. 105. fra Folketingets Sundheds- og Ældreudvalg. 2017;Sept 26.
[125] Gøtzsche PC. DSAM-formand på afveje om antidepressiva. Dagens Medicin 2017;Mar 8.
[126] Gøtzsche PC. Antidepressiva skader mere end de gavner. Dagens Medicin 2017;Mar 15.
[127] Gøtzsche P. The meeting was sponsored by merchants of death. Mad in America 2014;July 7.
[128] Moncrieff J, Wessely S, Hardy R. Active placebos versus antidepressants for depression. Cochrane Database Syst Rev 2004;1:CD003012.
[129] Jakobsen JC, Katakam KK, Schou A, et al. Selective serotonin reuptake inhibitors versus placebo in patients with major depressive disorder. A systematic review with meta-analysis and Trial Sequential Analysis. BMC Psychiatry 2017;17:58.
[130] Gøtzsche PC, Gøtzsche PK. Cognitive behavioural therapy halves the risk of repeated suicide attempts: systematic review. J R Soc Med 2017;110:404-10.
[131] Davies J, Read J, Kruger D, et al. Politicians, experts, and patient representatives call for the UK government to reverse the rate of antidepressant prescribing BMJ 2023;383:p2730 and Gøtzsche PC. Antidepressants do not work for very severe depression either. BMJ 2023;Dec 5.
[132] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 73.
[133] Gibbons RD, Hur K, Brown CH, et al. Benefits from antidepressants: synthesis of 6-week patient-level outcomes from double-blind placebo-controlled randomized trials of fluoxetine and venlafaxine. Arch Gen Psychiatry 2012;69:572-9.
[134] Karle J, Bauer J. Vildledning om medicin mod depression. Politiken 2011;April 1 and Søgaard HJ. Forvansket kritik af antidepressiva. Ugeskr Læger 2011;173:1225.
[135] Gøtzsche PC. Vigtig debat om gavnlige og skadelige virkninger. Dagens Medicin 2011;May 6.
[136] Staahltoft D. Misinformation? Ugeskr Læger 2011;173:1453.
[137] Kornø K, Svensson TG. Lykkepilleskandalen: Jeg får penge fra alle firmaer i kongeriget. Ekstra Bladet 2011;May 28 and Eksperter i antidepressiver arbejder for medicinalfirmaer. Politiken 2011;May 28.
[138] Hróbjartsson A, Gøtzsche PC. Is the placebo powerless? An analysis of clinical trials comparing placebo with no treatment. N Engl J Med 2001;344:1594-602 and Hróbjartsson A, Gøtzsche PC. Placebo interventions for all clinical conditions. Cochrane Database Syst Rev 2010;1:CD003974.
[139] Bauer J, Karle J. Vildledning om medicin mod depression. Politiken 2011;Apr 1.
[140] Gøtzsche PC. Psykiaterne har ukritisk accepteret ssri-præparaterne. Dagens Medicin 2011;April 7.
[141] Kessing L, Hansen HV, Demyttenaere K, et al. Depressive and bipolar disorders: patients' attitudes and beliefs towards depression and antidepressants. Psychological Medicine 2005;35:1205-13.
[142] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015, page 161.
[143] Bockting CL, ten Doesschate MC, Spijker J, et al. Continuation and maintenance use of antidepressants in recurrent depression. Psychother Psychosom 2008;77:17-26.
[144] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 70.
[145] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 18.

[146] Nour MM, Liu Y, Dolan RJ. Functional neuroimaging in psychiatry and the case for failing better. Neuron 2022;110:2524-44.
[147] http://ugeskriftet.dk/nyhed/der-er-ild-i-sengen-og-saa-taler-vi-om-psykofarmaka-1 (see Videbech's electronic comments).
[148] Videbech P. Debatten om antidepressiv medicin - Virker det, og bliver man afhængig? BestPractice Psykiatri/Neurologi 2014;May:nr. 25.
[149] Gøtzsche PC. Benzodiazepines and risk of Alzheimer's disease. BMJ 2014;Oct 6.
[150] Ownby RL, Crocco E, Acevedo A, et al. Depression and risk for Alzheimer disease: systematic review, meta-analysis, and meta-regression analysis. Arch Gen Psychiatry 2006;63:530-8.
[151] Moraros J, Nwankwo C, Patten SB, Mousseau DD. The association of antidepressant drug usage with cognitive impairment or dementia, including Alzheimer disease: A systematic review and meta-analysis. Depress Anxiety 2017;34:217-26 and Coupland CAC, Hill T, Dening T, et al. Anticholinergic drug exposure and the risk of dementia: a nested case-control study. JAMA Intern Med 2019;Jun 24.
[152] Gøtzsche PC. Brug psykofarmaka mindre og bedre. Weekendavisen 2014;Jan 31.
[153] Sharma T, Guski LS, Freund N, Meng DM, Gøtzsche PC. Drop-out rates in placebo-controlled trials of antidepressant drugs: A systematic review and meta-analysis based on clinical study reports. Int J Risk Saf Med 2019;30:217-32.
[154] Paludan-Müller AS, Sharma T, Rasmussen K, Gøtzsche PC. Extensive selective reporting of quality of life in clinical study reports and publications of placebo-controlled trials of antidepressants. Int J Risk Saf Med 2021;32:87-99.
[155] Spørgsmål nr. 1063 fra Folketingets Sundheds- og Ældreudvalg. 2017;Sept 26.
[156] FDA package insert for Lexapro (escitalopram).
[157] Benkert O, Szegedi A, Wetzel H, et al. Dose escalation vs. continued doses of paroxetine and maprotiline: a prospective study in depressed out-patients with inadequate treatment response. Acta Psychiatr Scand 1997;95:288-96; Kirsch I, Moore TJ, Scoboria, A, et al. The emperor's new drugs: An analysis of antidepressant medication data submitted to the U.S. Food and Drug Administration. Prevention & Treatment 2002;5:Article 23; Bech P, Kajdasz DK, Porsdal V. Dose-response relationship of duloxetine in placebo-controlled clinical trials in patients with major depressive disorder. Psychopharmacology 2006;188:273-80; Santaguida P, MacQueen G, Keshavarz H, et al. Treatment for depression after unsatisfactory response to SSRIs. Comparative Effectiveness Review No. 62. (Prepared by McMaster University Evidence-based Practice Center under Contract No. HHSA 290 2007 10060 I.) AHRQ Publication No.12-EHC050-EF. Rockville, MD: Agency for Healthcare Research and Quality 2012; April; Hieronymus F, Nilsson S, Eriksson E. A mega-analysis of fixed-dose trials reveals dose-dependency and a rapid onset of action for the antidepressant effect of three selective serotonin reuptake inhibitors. Transl Psychiatry 2016;6:e834; Rink L, Braun C, Bschor T, et al. Dose increase versus unchanged continuation of antidepressants after initial antidepressant treatment failure in patients with major depressive disorder: a systematic review and meta-analysis of randomized, double-blind trials. J Clin Psychiatry 2018;79:17r11693; FDA package insert for Lexapro (escitalopram). Accessed 18 April 2022; FDA package insert for Celexa (citalopram). Accessed 18 April 2022; Gøtzsche PC, Healy D. Restoring the two pivotal fluoxetine trials in children and adolescents with depression. Int J Risk Saf Med 2022;33:385-408.
[158] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, pages 74-77; Miller M, Swanson SA, Azrael D, et al. Antidepressant dose, age, and the risk of deliberate self-harm. JAMA Intern Med 2014;174:899-909; Healy D, Herxheimer A, Menkes DB. Antidepressants and violence: problems at the interface of medicine and law. PLoS Med 2006;3:e372; Hubbard R, Farrington P, Smith C, et al. Exposure to tricyclic and selective serotonin reuptake inhibitor antidepressants and the risk of hip fracture. Am J Epidemiol 2003;158:77-84; Thapa PB, Gideon P, Cost TW, et al. Antidepressants and the risk of falls among nursing home residents. N Engl J Med 1998;339:875-82; Khanassov V, Hu J, Reeves D, van Marwijk H. Selective serotonin reuptake inhibitor and selective serotonin and norepinephrine reuptake inhibitor use and risk of fractures in adults: A systematic review and meta-analysis. Int J Geriatr Psychiatry 2018;33:1688-1708.
[159] Meyer JH, Wilson AA, Sagrati S, et al. Serotonin transporter occupancy of five selective serotonin reuptake inhibitors at different doses: an [11C]DASB positron emission tomography study. Am J Psychiatry 2004;161:826-35.
[160] UK fluoxetine Summary of Product Characteristics. Accessed 20 April 2022.
[161] Jauhar S, Morrison P. Esketamine for treatment resistant depression. We should cautiously welcome this new therapeutic option. BMJ 2019;366:l5572.
[162] Gøtzsche PC, Hengartner MP, Davies J, et al. Esketamine for treatment resistant depression. BMJ 2019;Oct 3.

[163] Lovelace B. FDA panel rejects first MDMA treatment amid deep concerns about flawed trials. NBC News 2024;June 4.
[164] Fuentes JJ, Fonseca F, Elices M, et al. Therapeutic use of LSD in psychiatry: a systematic review of randomized-controlled clinical trials. Front Psychiatry 2020;10:943.
[165] Gøtzsche PC. Number needed to treat with a psychiatric drug to benefit one patient is an illusion. Mad in America 2022;Dec 13.
[166] Sharma T, Guski LS, Freund N, Meng DM, Gøtzsche PC. Drop-out rates in placebo-controlled trials of antidepressant drugs: A systematic review and meta-analysis based on clinical study reports. Int J Risk Saf Med 2019;30:217-32.
[167] Montejo A, Llorca G, Izquierdo J, et al. Incidence of sexual dysfunction associated with antidepressant agents: a prospective multicenter study of 1022 outpatients. Spanish Working Group for the study of psychotropic-related sexual dysfunction. J Clin Psychiatry 2001;62 (suppl 3):10–21.
[168] Babyak M, Blumenthal JA, Herman S, et al. Exercise treatment for major depression: maintenance of therapeutic benefit at 10 months. Psychosom Med 2000;62:633–8.
[169] Noetel M, Sanders T, Gallardo-Gómez D, et al. Effect of exercise for depression: systematic review and network meta-analysis of randomised controlled trials. BMJ 2024;384:e075847.
[170] Cipriani A, Furukawa TA, Salanti G, et al. Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis. Lancet 2018;391:1357-66.
[171] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 118.
[172] Timimi S, Moncrieff J, Gøtzche P, et al. Network meta-analysis of antidepressants. Lancet 2018;392:1011-2.
[173] Gøtzsche PC. Rewarding the companies that cheated the most in antidepressant trials. Mad in America 2018;March 7.
[174] Koesters M, Guaiana G, Cipriani A, et al. Agomelatine efficacy and acceptability revisited: systematic review and meta-analysis of published and unpublished randomised trials. Br J Psychiatry 2013;203:179-87.
[175] Gorman JM, Korotzer A, Su G. Efficacy comparison of escitalopram and citalopram in the treatment of major depressive disorder: pooled analysis of placebo-controlled trials. CNS Spectr 2002;7(4 Suppl. 1):40-4.
[176] Dyer O. Lundbeck broke advertising rules. BMJ 2003;326:1004.
[177] Alkhafaji AA, Trinquart L, Baron G, et al. Impact of evergreening on patients and health insurance: a meta analysis and reimbursement cost analysis of citalopram/escitalopram antidepressants. BMC Med 2012;10:142.
[178] Gøtzsche PC. Deadly medicines and organised crime: How big pharma has corrupted health care. London: Radcliffe Publishing; 2013, page 228.
[179] Cipriani A, Santilli C, Furukawa TA, et al. Escitalopram versus other antidepressive agents for depression. Cochrane Database Syst Rev 2009;2:CD006532.
[180] Carlsen LT. En svær balance. Tænk + Test 2003;32:30-3.
[181] Lindberg M. Interessant hensyn til eksporten. Dagens Medicin 2002;Nov 29.
[182] Lægemiddelstyrelsen giver Lundbeck medvind. Politiken 2004;Sept 13.
[183] Behandling med antidepressiva. Institut for Rationel Farmakoterapi 2004;Sept 10.
[184] Dyer O. Lundbeck broke advertising rules. BMJ 2003;326:1004.
[185] Antitrust: Commission fines Lundbeck and other pharma companies for delaying market entry of generic medicines. European Commission Press release 2013;June 19.
[186] Cosgrove L, Vannoy S, Mintzes B, et al. Under the influence: the interplay among industry, publishing, and drug regulation. Account Res 2017;24:99-115.
[187] Therrien A. Anti-depressants: Major study finds they work. BBC News 2018;Feb 22.
[188] Karen Thisted fik mod på livet: lykkepillerne der virker. Region Hovedstaden Bibtex 2018;Mar 26.
[189] Videbech P, Kjølbye M, Sørensen T, Vestergaard P (red.). Psykiatri. En lærebog om voksnes psykiske sygdomme. København: FADL's Forlag; 2018.
[190] Hutton B, Salanti G, Caldwell DM, et al. The PRISMA extension statement for reporting of systematic reviews incorporating network meta-analyses of health care interventions: checklist and explanations. Ann Intern Med 2015;162:777-84.
[191] Gøtzsche PC. Bias in double-blind trials. Dan Med Bull 1990;37:329-36; Gøtzsche PC. Deadly medicines and organised crime: How big pharma has corrupted health care. London: Radcliffe Publishing; 2013; Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015.
[192] Barbui C, Cipriani A, Brambilla P, et al. "Wish bias" in antidepressant drug trials? J Clin Psychopharmacol 2004;24:126-30.

[193] Munkholm K, Paludan-Müller AS, Boesen K. Considering the methodological limitations in the evidence base of antidepressants for depression: a reanalysis of a network meta-analysis. BMJ Open 2019;9:e024886.
[194] Kirsch I, Deacon BJ, Huedo-Medina TB, et al. Initial severity and antidepressant benefits: A meta-analysis of data submitted to the Food and Drug Administration. PLoS Med 2008;5:e45.
[195] Cipriani A, Zhou X, Del Giovane C, et al. Comparative efficacy and tolerability of antidepressants for major depressive disorder in children and adolescents: a network meta-analysis. Lancet 2016;388:881-90.
[196] Melander H, Ahlqvist-Rastad J, Meijer G, et al. Evidence b(i)ased medicine – selective reporting from studies sponsored by pharmaceutical industry: review of studies in new drug applications. BMJ 2003;326:1171–3; Turner EH, Matthews AM, Linardatos E, et al. Selective publication of antidepressant trials and its influence on apparent efficacy. N Engl J Med 2008;358:252-60; Le Noury J, Nardo JM, Healy D, et al. Restoring Study 329: efficacy and harms of paroxetine and imipramine in treatment of major depression in adolescence. BMJ 2015;351:h4320; Sharma T, Guski LS, Freund N, et al. Suicidality and aggression during antidepressant treatment: systematic review and meta-analyses based on clinical study reports. BMJ 2016;352:i65; Maund E, Guski LS, Gøtzsche PC. Considering benefits and harms of duloxetine for treatment of stress urinary incontinence: a meta-analysis of clinical study reports. CMAJ 2017;189:E194-203; Maund E, Tendal B, Hróbjartsson A, Jørgensen KJ, Lundh A, Schroll J, Gøtzsche PC. Benefits and harms in clinical trials of duloxetine for treatment of major depressive disorder: comparison of clinical study reports, trial registries, and publications. BMJ 2014;348:g3510; Sharma T, Guski LS, Freund N, et al. Drop-out rates in placebo-controlled trials of antidepressant drugs: A systematic review and meta-analysis based on clinical study reports. Int J Risk Saf Med 2019;30:217-32; Hengartner MP, Plöderl M. Newer-generation antidepressants and suicide risk in randomized controlled trials: a re-analysis of the FDA database. Psychother Psychosom 2019;88:247-8; Hengartner MP, Plöderl M. Reply to the Letter to the Editor: "Newer-Generation Antidepressants and Suicide Risk: Thoughts on Hengartner and Plöderl's ReAnalysis." Psychother Psychosom 2019;88:373-4; Gøtzsche PC, Healy D. Restoring the two pivotal fluoxetine trials in children and adolescents with depression. Int J Risk Saf Med 2022;33:385-408.
[197] Skausig OB. Skal man ordinere det bedste eller det billigste? Dagens Medicin 2011;June 10.
[198] Gøtzsche PC, Maund E, Tendal B. Læs lærebøgerne, Gøtzsche (svar til). Ugeskr Læger 2012;174:888-9.
[199] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 118.
[200] Pigott HE, Leventhal AM, Alter GS, et al. Efficacy and effectiveness of antidepressants: current status of research. Psychother Psychosom 2010;79:267-79.
[201] Pigott HE, Leventhal AM, Alter GS, et al. Efficacy and effectiveness of antidepressants: current status of research. Psychother Psychosom 2010;79:267-79.
[202] Whitaker R. The STAR*D scandal: a new paper sums it all up. Mad in America 2010;Aug 27.
[203] Kirk SA, Gomory T, Cohen D. Mad science: psychiatric coercion, diagnosis and drugs. New Brunswick: Transaction Publishers; 2013.
[204] Pigott E. STAR*D: Adding fiction to fiction. Mad in America 2011;Apr 10.
[205] Pigott HE, Kim T, Xu C, et al. What are the treatment remission, response and extent of improvement rates after up to four trials of antidepressant therapies in real-world depressed patients? A reanalysis of the STAR*D study's patient-level data with fidelity to the original research protocol. BMJ Open 2023;13:e063095.
[206] Trivedi MH, Rush AJ, Wisniewski SR, et al. Evaluation of outcomes with citalopram for depression using measurement-based care in STAR*D: implications for clinical practice. Am J Psychiatry 2006;163:28-40.
[207] Whitaker R. After MIA calls for retraction of STAR*D article, study authors double down on the fraud. Mad in America 2023;Dec 6.
[208] Whitaker R. The STAR*D scandal: scientific misconduct on a grand scale. Mad in America 2023;Sept 9.
[209] Badre N, Compton J. STAR*D: It's time to atone and retract. Psychiatric Times 2024;May 25.
[210] Whitaker R. The New York Times is now engulfed in the STAR*D scandal. Mad in America 2024;April 27.
[211] Caron C. What you really need to know about antidepressants. New York Times 2024;April 25.
[212] Levine BE. New York Times sinks to new low in its psychiatric drug coverage. Counterpunch 2024;May 8.
[213] Hetrick SE, McKenzie JE, Bailey AP, et al. New generation antidepressants for depression in children and adolescents: a network meta-analysis. Cochrane Database Syst Rev 2021;5:CD013674.
[214] Gøtzsche PC. Garbage in, garbage out: the newest Cochrane meta-analysis of depression pills in children. Mad in America 2021;Aug 19.
[215] Gøtzsche PC, Healy D. Restoring the two pivotal fluoxetine trials in children and adolescents with depression. Int J Risk Saf Med 2022;33:385-408.

[216] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015; Gøtzsche PC. Deadly medicines and organised crime: How big pharma has corrupted health care. London: Radcliffe Publishing; 2013; Healy D. Let them eat Prozac. New York: New York University Press; 2004; Healy D, Cattell D. Interface between authorship, industry and science in the domain of therapeutics. Br J Psychiatry 2003;183:22-7; Lenzer J. FDA to review "missing" drug company documents. BMJ 2005;330:7; Healy D. SSRIs and deliberate self-harm. Br J Psychiatry 2002;180:547; Healy D. Did regulators fail over selective serotonin reuptake inhibitors? BMJ 2006;333:92-5;
[217] Laughren TP. Overview for December 13 Meeting of Psychopharmacologic Drugs Advisory Committee (PDAC). FDA 2006;Nov 16.
[218] Stipp D. Trouble in Prozac. CNN Money 2005;Nov 28.
[219] Lenzer J. Crisis deepens at the US Food and Drug Administration. BMJ 2004;329:1308.
[220] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015: page 70.
[221] Laughren TP. The scientific and ethical basis for placebo-controlled trials in depression and schizophrenia: an FDA perspective. Eur Psychiatry 2001;16:418-23.
[222] Laughren TP. Overview for December 13 Meeting of Psychopharmacologic Drugs Advisory Committee (PDAC). FDA 2006;Nov 16 and Hammad TA, Laughren T, Racoosin J. Suicidality in pediatric patients treated with antidepressant drugs. Arch Gen Psychiatry 2006;63:332-9.
[223] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 79.
[224] Boseley S. They said it was safe. The Guardian 1999;Oct 30 and Breggin P. Medication madness. New York: St. Martin's Griffin; 2008.
[225] Whitaker R. Mad in America. Cambridge: Perseus Books Group; 2002; [225] Crowner ML, Douyon R, Convit A, Gaztanaga P, Volavka J, Bakall R. Akathisia and violence. Psychopharmacol Bull 1990;26:115-7; Medawar C. The antidepressant web - marketing depression and making medicines work. Int J Risk & Saf Med 1997;10:75-126; Moncrieff J, Cohen D, Mason JP. The subjective experience of taking antipsychotic medication: a content analysis of Internet data. Acta Psychiatr Scand 2009;120:102-11.
[226] Videbech P, Kjølbye M, Sørensen T, Vestergaard P (red.). Psykiatri. En lærebog om voksnes psykiske sygdomme. København: FADL's Forlag; 2018, page 119.
[227] Gøtzsche PC. Åbent brev til Lundbeck om antidepressiva og selvmord. Videnskab.dk 2011;July 7.
[228] Pedersen AG. Lundbecks svar på Peter Gøtzsches åbne brev om antidepressiva og selvmord. Videnskab.dk 2001;July 8.
[229] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, pages 95-102.
[230] Søndergård L, Kvist K, Andersen PK, et al. Do antidepressants precipitate youth suicide? A nationwide pharmacoepidemiological study. Eur Child Adolesc Psychiatry 2006;15:232-40.
[231] Hjorthøj CR, Madsen T, Agerbo E, et al. Risk of suicide according to level of psychiatric treatment: a nationwide nested case-control study. Soc Psychiatry Psychiatr Epidemiol 2014;49:1357–65.
[232] Videbech P. Nej, Peter Gøtzsche: Medicin mod depression er ikke tosset. Det er faktisk ekstremt nyttigt. Politiken 2020;March 5.
[233] Gøtzsche PC. Usage of depression pills almost halved among children in Denmark. Mad in America 2018;May 4.
[234] Gøtzsche PC. Denmark is the only European country where the usage of depression pills has dropped. Mad in America 2022;Nov 22.
[235] Aftenshowet. A debate about depression drugs with professor of psychiatry Lars Kessing (in Danish). DR TV 2013;April 15.
[236] Pedersen AT. Diagnosing psychiatry. Documentary film 2017.
[237] Kessing L. Hvordan kan Gøtzsche citere så forkert? Dagens Medicin 2013;May 3.
[238] Gøtzsche PC. SSRI kan føre til selvmord. Dagens Medicin 2013;May 3.
[239] Dowrick C, Frances A. Medicalising unhappiness: new classification of depression risks more patients being put on drug treatment from which they will not benefit. BMJ 2013;347:f7140.
[240] Wakefield JC. Misdiagnosing normality: Psychiatry's failure to address the problem of false positive diagnoses of mental disorder in a changing professional environment. J Ment Health 2010;19:337-51.
[241] Levine B. Depression: psychiatry's discredited theories and drugs versus a sane model and approach. Mad in America 2024;Feb 24.
[242] Gøtzsche PC. Antidepressiva øger risikoen for selvmord og vold i alle aldre. Medicinsk Tidsskrift 2016;Nov 20.

[243] Sharma T, Guski LS, Freund N, et al. Suicidality and aggression during antidepressant treatment: systematic review and meta-analyses based on clinical study reports. BMJ 2016;352:i65; Maund E, Tendal B, Hróbjartsson A, Jørgensen KJ, Lundh A, Schroll J, Gøtzsche PC. Benefits and harms in clinical trials of duloxetine for treatment of major depressive disorder: comparison of clinical study reports, trial registries, and publications. BMJ 2014;348:g3510; Maund E, Guski LS, Gøtzsche PC. Considering benefits and harms of duloxetine for treatment of stress urinary incontinence: a meta-analysis of clinical study reports. CMAJ 2017;189:E194-203; Bielefeldt AØ, Danborg PB, Gøtzsche PC. Precursors to suicidality and violence on antidepressants: systematic review of trials in adult healthy volunteers. J R Soc Med 2016;109:381-92.
[244] Gøtzsche PC. Antidepressiva bör inte användas till barn och ungdomar. Läkartidningen 2017;March 12.
[245] Hengartner MP, Plöderl M. Newer-generation antidepressants and suicide risk in randomized controlled trials: a re-analysis of the FDA database. Psychother Psychosom 2019;88:247-8 and Hengartner MP, Plöderl M. Reply to the Letter to the Editor: "Newer-Generation Antidepressants and Suicide Risk: Thoughts on Hengartner and Plöderl's Re-Analysis." Psychother Psychosom 2019;88:373-4.
[246] Sharma T, Guski LS, Freund N, Gøtzsche PC. Suicidality and aggression during antidepressant treatment: systematic review and meta-analyses based on clinical study reports. BMJ 2016;352:i65.
[247] ISEPP calls for a Federal Investigation into the link between Psychotropic Drugs and Mass Murder. International Society for Ethical Psychology and Psychiatry 2013;Jan 4.
[248] Healy D. Reply to D. Wilkinson – Loss of anxiety and increased aggression in a 15-year-old boy taking fluoxetine. J Psychopharmacol 1999;13:421.
[249] Dubicka B, Cole-King A, Reynolds S, et al. Paper on suicidality and aggression during antidepressant treatment was flawed and the press release was misleading. BMJ 2016;352:i911.
[250] Stone M. Suicidality and aggression during antidepressant treatment: authors misinterpreted earlier paper from the FDA. BMJ 2016;352:i906.
[251] Gøtzsche PC. Author's reply to Dubicka and colleagues and Stone. BMJ 2016;352:i915.
[252] Slagstad K. Øker antidepressiver selvmordsfaren? Tidsskr Nor Legeforen 2016;136:531.
[253] Gøtzsche PC. Antidepressants are dangerous. BMJ 2015;March 29.
[254] Bielefeldt AØ, Danborg PB, Gøtzsche PC. Precursors to suicidality and violence on antidepressants: systematic review of trials in adult healthy volunteers. J R Soc Med 2016;109:381-92.
[255] Moore TJ, Glenmullen J, Furberg CD. Prescription drugs associated with reports of violence towards others. PLoS One 2010;5:e15337.
[256] Gøtzsche PC. Endnu et tragisk selvmord på depressionspiller. Jyllands-Postens Kronik 2018;Feb 3.
[257] Gøtzsche PC. Børn drives til selvmord med lykkepiller. Regionsavisen 2024;Mar 11 and Buchholtz PE. Antidepressiv medicin forebygger selvmord blandt svært deprimerede patienter. Jyllands-Posten 2018;Feb 17.
[258] Gøtzsche PC, Gøtzsche PK. Cognitive behavioural therapy halves the risk of repeated suicide attempts: systematic review. J R Soc Med 2017;110:404-10.
[259] Johansen M, Vibjerg T. Hvorfor tog den 19-årige Rasmus Toke Burchardt sit eget liv? Jyllands-Posten 2018;Feb 3.
[260] Gøtzsche PC. Open letter to National Boards of Health in Iceland, Norway, Sweden and Finland: Warning against using depression pills in children and adolescents. Deadly Medicines 2019;Jan 22.
[261] Gøtzsche PC. National Boards of Health are unresponsive to children driven to suicide by depression pills. Mad in America 2020;March 15.
[262] Läkemedelsbehandling av depression, ångestsyndrom och tvångssyndrom hos barn och vuxna. Läkemedelsverket 2016;Dec 8.
[263] Gøtzsche PC. National boards of health are unresponsive to children driven to suicide by depression pills. Mad in America 2020;Mar 15.
[264] Barczyk ZA, Rucklidge JJ, Eggleston M, Mulder RT. Psychotropic medication prescription rates and trends for New Zealand children and adolescents 2008-2016. J Child Adolesc Psychopharmacol 2020;30:87-96.
[265] UNICEF Office of Research. Building the future: children and the sustainable development goals in rich countries. Innocenti ReportCard 14; UNICEF Office of Research 2017.
[266] Strawn JR, Moldauer L, Hahn RD, et al. A multicenter double-blind, placebo-controlled trial of escitalopram in children and adolescents with generalized anxiety disorder. J Child Adolesc Psychopharmacol 2023;33:91-100.
[267] Gøtzsche PC. Driving our children into suicide with escitalopram and other happy pills. Mad in America 2023;Aug 3.

[268] Gøtzsche PC, Healy D. Restoring the two pivotal fluoxetine trials in children and adolescents with depression. Int J Risk Saf Med 2022;33:385-408.
[269] Gøtzsche PC. Deadly medicines and organised crime: How big pharma has corrupted health care. London: Radcliffe Publishing; 2013; Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015.
[270] Hjelmeland H, Jaworski K, Knizek BL, Ian M. Problematic advice from suicide prevention experts. Ethical Human Psychology and Psychiatry 2018;20:79-85.
[271] Whitaker R, Blumke D. Screening + drug treatment = increase in veteran suicides. Mad in America 2019;Nov 10.
[272] Hjelmeland H, Knizek BL. Suicide and mental disorders: A discourse of politics, power, and vested interests. Death Stud 2017;41:481-92.
[273] Frankfurt HG. On bullshit. New Jersey: Princeton University Press; 2005.
[274] Schopenhauer A. The art of always being right. London: Gibson Square; 2009.
[275] Zalsman G, Hawton K, Wasserman D, et al. Evidence-based national suicide prevention taskforce in Europe: A consensus position paper. Eur Neuropsychopharmacol 2017;27:418-21.
[276] Hjelmeland H, Jaworski K, Knizek BL, Ian M. Problematic advice from suicide prevention experts. Ethical Human Psychology and Psychiatry 2018;20:79-85.
[277] Espeland K, Knizek BL, Hjelmeland H. "Time to try something new" - professionals' experiences and reflections on suicide prevention in Norway. Crisis 2021;42:434-40.
[278] Mann JJ, Michel CA, Auerbach RP. Improving suicide prevention through evidence-based strategies: a systematic review. Am J Psychiatry 2021;178:611-24.
[279] Hengartner MP, Plöderl M. Newer-generation antidepressants and suicide risk in randomized controlled trials: a re-analysis of the FDA database. Psychother Psychosom 2019;88:247-8 and Hengartner MP, Plöderl M. Reply to the Letter to the Editor: "Newer-Generation Antidepressants and Suicide Risk: Thoughts on Hengartner and Plöderl's ReAnalysis." Psychother Psychosom 2019;88:373-4.
[280] Bolton JM, Gunnell D, Turecki G. Suicide risk assessment and intervention in people with mental illness. BMJ 2015;351:h4978.
[281] Gøtzsche PC. No psychiatric drugs have been convincingly shown to decrease suicides. BMJ 2015;Dec 10.
[282] Meltzer HY, Alphs L, Green AI, et al. Clozapine treatment for suicidality in schizophrenia: International Suicide Prevention Trial (InterSePT). Arch Gen Psychiatry 2003;60:82-91.
[283] Mills JL. Data torturing. N Engl J Med 1993;329:1196-9.
[284] Cipriani A, Hawton K, Stockton S, et al. Lithium in the prevention of sui¬cide in mood disorders: updated systematic review and meta-analysis. BMJ 2013;346:f3646.
[285] Gøtzsche PC. Ingen pålitlig evidens visar att läkemedel kan förebygga självmord. Läkartidningen 2017;May 1.
[286] Gøtzsche PC. Deadly medicines and organised crime: How big pharma has corrupted health care. London: Radcliffe Publishing; 2013.
[287] Suicide prevention. National Institute of Mental Health. Undated.
[288] Knipe D, Padmanathan P, Newton-Howes G, et al. Suicide and self-harm. Lancet 2022;399:1903-16.
[289] Gøtzsche PC. A hopelessly flawed seminar in "The Lancet" about suicide. Mad in America 2022;June 1.
[290] Moncrieff J, Cooper RE, Stockmann T, et al. The serotonin theory of depression: a systematic umbrella review of the evidence. Mol Psychiatry 2023;28:3243-56.
[291] FDA package insert for Lyrica (pregabalin).
[292] Hjorthøj CR, Madsen T, Agerbo E, et al. Risk of suicide according to level of psychiatric treatment: a nationwide nested case-control study. Soc Psychiatry Psychiatr Epidemiol 2014;49:1357–65.
[293] Goldney RD. Suicide and antidepressants: what is the evidence? Aust N Z J Psychiatry 2006;40:381-5.
[294] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 97.
[295] Zahl PH, De Leo D, Ekeberg Ø, et al. The relationship between sales of SSRI, TCA and suicide rates in the Nordic countries. BMC Psychiatry 2010;10:62.
[296] Smith R. Medical journals are an extension of the marketing arm of pharmaceutical companies. PLoS Med 2005;2:e138.
[297] Friedman RA. Antidepressants' black-box warning - 10 years later. N Engl J Med 2014;371:1666-8.
[298] Hughes JL, Horowitz LM, Ackerman JP, et al. Suicide in young people: screening, risk assessment, and intervention. BMJ 2023;381:e070630.
[299] Gøtzsche PC. Depression drugs have been shown to double the risk of suicide in young people and should not be used. BMJ 2023;April 26.

[300] Gøtzsche PC. The lie that antidepressants protect against suicide is deadly. Mad in America 2023;Nov 28.
[301] Jakobsen SG, Christiansen E. Selvmordsforsøg og antidepressiva. Center for Selvmordsforskning 2019;Dec.
[302] Risiko for selvmord og vold påvirkes ikke af antidepressiv behandling. Region Hovedstadens Psykiatri 2023.
[303] Antidepressiva øger ikke risikoen for selvmord. Fluoxetin og venlafaxin øger ikke risikoen for selvmord blandt unge. Blandt voksne og ældre, beskytter præparaterne mod selvmord. Region Hovedstadens Psykiatri 2023.
[304] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 96.
[305] Antidepressiva øger risikofaktorer for selvmord. Psykiatrisk Tidsskrift 2016;Nov 20.
[306] Bielefeldt AØ, Danborg PB, Gøtzsche PC. Precursors to suicidality and violence on antidepressants: systematic review of trials in adult healthy volunteers. J R Soc Med 2016;109:381-92.
[307] PhVWP/CMD(H) vedtaget SPC ordlyd for alle antidepressiva: selvmordstanker og selvmordsadfærd. Danish Drug Agency, undated.
[308] Geoffroy MB. Unges selvmord og antidepressiva. Peter Gøtzsche hævder, at antidepressiva har drevet unge til selvmord. Men hvordan kan han vide det? Ugeskr Læger 2023;July 10.
[309] Geoffroy MB. Hvilket kontor stopper vildfarne professorer? Dagens Medicin 2015;Sept 25.
[310] Kortegaard L. Er psykiaterne på gyngende grund? Dagens Medicin 2015;Oct 9 and Gøtzsche PC. Psykiateren prøver at skyde budbringeren. Dagens Medicin 2015;Oct 9.
[311] Schultz J. Peter Gøtzsche melder psykiater til Lægeetisk Nævn. Dagens Medicin 2015;Oct 2.
[312] Geoffroy MB. Ingen over Gøtzsche. Dagens Medicin 2015;Oct 23.
[313] Geoffroy MB. Interessekonflikter – mere end ussel mammon. Ugeskr Læger 2016;178:1838-9.
[314] Gøtzsche PC. Begrebet interessekonflikter bør ikke udvandes. Ugeskr Læger 2016;178:1840.
[315] Sammenhængen mellem antidepressiv/stemnings-stabiliserende medicin og selvmord. Ugeskr Læger 2007;June 8.
[316] Gøtzsche PC. Misinformation om antidepressiva og selvmord. www.irf.dk 2015;March 5.
[317] Barse M. Forskere: 'Lykkepiller' giver bivirkninger, som kan føre til selvmordsadfærd. Videnskab.dk 2017;Feb 11.
[318] Maund E, Guski LS, Gøtzsche PC. Considering benefits and harms of duloxetine for treatment of stress urinary incontinence: a meta-analysis of clinical study reports. CMAJ 2017;189:E194-203.
[319] Gøtzsche PC. Endnu et tragisk selvmord på depressionspiller. Jyllands-Postens Kronik 2018;Feb 3.
[320] https://www.samaritans.org/?currency=EUR
[321] Newman KB. Get suicide prevention services to ask callers if they are taking meds that cause suicide. Petition launched 2024;Apr 21.
[322] Newman KB. I was sectioned after being given a tranquiliser for anxiety that triggered a frightening slide into psychosis. But the worst part of my ordeal was how doctors tried to cure me. Daily Mail 2024;Apr 23.
[323] Whitaker R. Den psykiatriske epidemi: illusionen om mirakelpillen. Søborg: Psykovisions Forlag; 2013.
[324] Videbech P. Drengen har jo ikke noget tøj på. Dagens Medicin 2013;Nov 11.
[325] Dalhof H. Det er kejseren, som er nøgen. Dagens Medicin 2013;Nov 22.
[326] Gøtzsche PC, Healy D. Restoring the two pivotal fluoxetine trials in children and adolescents with depression. Int J Risk Saf Med 2022;33:385-408.
[327] Nilsson M, Joliat MJ, Miner CM, et al. Safety of subchronic treatment with fluoxetine for major depressive disorder in children and adolescents. J Child Adolesc Psychopharmacol 2004;14:412-7.
[328] Tauscher-Wisniewski S, Nilsson M, Caldwell C, et al. Meta-analysis of aggression and/or hostility-related events in children and adolescents treated with fluoxetine compared with placebo. J Child Adolesc Psychopharmacol 2007;17:713-8.
[329] Mosholder AD. Application number: 18-936/SE5-064. Medical review. FDA 2001;Oct 4.
[330] Offidani E, Fava GA, Tomba E, et al. Excessive mood elevation and behavioral activation with antidepressant treatment of juvenile depressive and anxiety disorders: a systematic review. Psychother Psychosom 2013;82:132-41.
[331] Baldessarini RJ, Faedda GL, Offidani E, et al. Antidepressant-associated mood switching and transition from unipolar major depression to bipolar disorder: a review. J Affect Disord 2013;148:129-35.
[332] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015 and Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 89.
[333] Gøtzsche PC. Depression drugs have been shown to double the risk of suicide in young people and should not be used. BMJ 2023;April 26.
[334] Gøtzsche PC. Call for retraction of three fraudulent trial reports of antidepressants in children and adolescents. Copenhagen: Institute for Scientific Freedom 2023;Aug 3.

[335] Gøtzsche PC. Medical journals refuse to retract fraudulent trial reports that omitted suicidal events in children. Mad in America 2024;Mar 18.
[336] March J, Silva S, Petrycki S, et al. Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents With Depression Study (TADS) randomized controlled trial. JAMA 2004;292:807-20.
[337] Högberg G, Antonuccio DO, Healy D. Suicidal risk from TADS study was higher than it first appeared. Int J Risk Saf Med 2015;27:85-91.
[338] Aboustate N, Jureidini J. Barriers to access to clinical trial data: Obstruction of a RIAT reanalysis of the treatment for adolescents with depression study. Int J Risk Saf Med 2022;33:299-308.
[339] Thomsen PH, Rask CU, Bilenberg N (red.). Børne- og ungdomspsykiatri. København: FADLs Forlag; 2019, page 215.
[340] A Letter from Russell Katz to GlaxoSmithKline. 2002;Oct 21.
[341] Keller MB, Ryan ND, Strober M, et al. Efficacy of paroxetine in the treatment of adolescent major depression: a randomized, controlled trial. J Am Acad Child Adolesc Psychiatry 2001;40:762-72.
[342] Jureidini JN, McHenry LB, Mansfield PR. Clinical trials and drug promotion: selective reporting of study 329. Int J Risk Safety Med 2008;20:73-81.
[343] Le Noury J, Nardo JM, Healy D, et al. Restoring Study 329: efficacy and harms of paroxetine and imipramine in treatment of major depression in adolescence. BMJ 2015;351:h4320.
[344] Bass A. Side effects - a prosecutor, a whistleblower, and a bestselling antidepressant on trial. Chapel Hill: Algonquin Books, 2008.
[345] Jureidini JN, McHenry LB. Conflicted medical journals and the failure of trust. Accountability in Research 2001;18:45–54.
[346] Hammad TA, Laughren T, Racoosin J. Suicidality in pediatric patients treated with antidepressant drugs. Arch Gen Psychiatry 2006;63:332-9.
[347] GlaxoSmithKline to plead guilty and pay $3 billion to resolve fraud allegations and failure to report safety data. United States Department of Justice 2012;July 2.
[348] Jureidini JN, McHenry LB, Mansfield PR. Clinical trials and drug promotion: selective reporting of study 329. Int J Risk Safety Med 2008;20:73–81.
[349] Jureidini JN, Amsterdam JD, McHenry LB. The citalopram CIT-MD-18 pediatric depression trial: Deconstruction of medical ghostwriting, data mischaracterisation and academic malfeasance. Int J Risk Saf Med 2016;28:33-43.
[350] Feeney A, Hock RS, Fava M, et al. Antidepressants in children and adolescents with major depressive disorder and the influence of placebo response: A meta-analysis. J Affect Disord 2022;305:55-64.
[351] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 56 and Gøtzsche PC, Healy D. Restoring the two pivotal fluoxetine trials in children and adolescents with depression. Int J Risk Saf Med 2022;33:385-408.
[352] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 97.
[353] FDA package insert for Lyrica (pregabalin).
[354] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 96.
[355] Demasi M, Gøtzsche PC. Presentation of benefits and harms of antidepressants on websites: cross sectional study. Int J Risk Saf Med 2020;31:53-65.
[356] Medawar C, Herxheimer A. A comparison of adverse drug reaction reports from professionals and users, relating to risk of dependence and suicidal behaviour with paroxetine. Int J Risk Saf Med 2003/2004;16:5-19.
[357] Medawar C, Hardon A. Medicines out of control? Antidepressants and the conspiracy of goodwill. Holland: Aksant Academic Publishers; 2004.
[358] Breggin P. Psychiatric drug withdrawal: A guide for prescribers, therapists, patients and their families. New York: Springer; 2012 and Lucire Y, Crotty C. Antidepressant-induced akathisia-related homicides associated with diminishing mutations in metabolizing genes of the CYP450 family. Pharmgenomics Pers Med 2011;4:65–81.
[359] Gøtzsche PC. Survival in an overmedicated world: look up the evidence yourself. Copenhagen: People's Press; 2019, page 114.
[360] Symposium "Wetenschap en Economie". Geneesmiddelenbulletin 2016;50:99-110.
[361] Newman KB. The pill that steals lives. London: John Blake; 2016.
[362] Gøtzsche PC. On the brink of murder because of an antidepressant. Mad in America 2024;Mar 28.
[363] https://www.antidepressantrisks.org/films?wix-vod-video-id=73528fa5f3da48bf9bfe77889f453cad&wix-vod-comp-id=comp-kme2lksu

[364] https://www.antidepressantrisks.org/
[365] Lucire Y, Crotty C. Antidepressant-induced akathisia-related homicides associated with diminishing mutations in metabolizing genes of the CYP450 family. Pharmgenomics Pers Med 2011;4:65–81 and Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 105.
[366] Paxil maker held liable in murder/suicide. Baum & Hedlund 2001;July 9.
[367] Boseley S. Murder, suicide. A bitter aftertaste for the 'wonder' depression drug. Guardian 2011;June 11.
[368] Healy D, Mangin D, Mintzes B. The ethics of randomized placebo controlled trials of antidepressants with pregnant women. Int J Risk Saf Med 2010;22:7-16 and Healy D, Le Noury J, Mangin D. Links between serotonin reuptake inhibition during pregnancy and neurodevelopmental delay/spectrum disorders: A systematic review of epidemiological and physiological evidence. Int J Risk Saf Med 2016;28:125-41.
[369] FDA package insert for Paxil (paroxetine).
[370] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 122.
[371] Referenceprogram for unipolar depression hos voksne. København: Sundhedsstyrelsen; 2007.
[372] Levinson-Castiel R, Merlob P, Linder N et al. Neonatal abstinence syndrome after in utero exposure to selective serotonin reuptake inhibitors in term infants. Arch Pediatr Adolesc Med 2006;160:173-6.
[373] Pedersen LH, Henriksen TB, Vestergaard M, et al. Selective serotonin reuptake inhibitors in pregnancy and congenital malformations: population based cohort study. BMJ 2009;339:b3569.
[374] Gøtzsche PC. Deadly medicines and organised crime: How big pharma has corrupted health care. London: Radcliffe Publishing; 2013, page 144.
[375] Gøtzsche PC. Screening pregnant women for depression. Mad in America 2014;May 5.
[376] Gøtzsche PC. Deadly medicines and organised crime. YouTube 2013;Oct 18.
[377] Anvendelse af psykofarmaka ved graviditet og amning: kliniske retningslinjer. Dansk Psykiatrisk Selskab, Dansk Selskab for Obstetrik og Gynækologi, Dansk Pædiatrisk Selskab, Dansk Selskab for Klinisk Farmakologi 2014;Oct 27.
[378] Pearson RM, Evans J, Kounali D, et al. Maternal depression during pregnancy and the postnatal period: risks and possible mechanisms for offspring depression at age 18 years. JAMA Psychiatry 2013;70:1312-9.
[379] Pedersen LH, Henriksen TB, Bech BH, et al. Prenatal antidepressant exposure and behavioral problems in early childhood - a cohort study. Acta Psychiatr Scand 2013;127:126-35.
[380] Villesen K. Medicinal-industri rådgiver læger om bivirkninger. Information 2011;May 30.
[381] Gøtzsche PC. Deadly medicines and organised crime: How big pharma has corrupted health care. London: Radcliffe Publishing; 2013.
[382] On the road with Peter Gøtzsche. News from the Australiasian Cochrane Centre 2015;March and August.
[383] Jureidini J, Gøtzsche PC, Parry P. Dreams of a quick fix, gone awry. Mad in America 2015;Jan 19.
[384] McGorry PD, Yung AR, Phillips LJ, et al. Randomized controlled trial of interventions designed to reduce the risk of progression to first-episode psychosis in a clinical sample with subthreshold symptoms. Arch Gen Psychiatry 2002;59:921-8.
[385] Stark J. McGorry aborts teen drug trial. Sydney Morning Herald 2011;Aug 21.
[386] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, pages 96-101.
[387] Medawar C. The antidepressant web - marketing depression and making medicines work. Int J Risk & Saf Med 1997;10:75-126.
[388] https://www.youtube.com/watch?v=ZMhsPnoIdy4
[389] Hickie IB, Rogers NL. Novel melatonin-based therapies: potential advances in the treatment of major depression. Lancet 2011;378:621-31.
[390] Koesters M, Guaiana G, Cipriani A, et al. Agomelatine efficacy and acceptability revisited: systematic review and meta-analysis of published and unpublished randomised trials. Br J Psychiatry 2013;203:179-87.
[391] Worsley R. Cochrane co-founder savages Aussie psychiatrists. 6minutes.com.au 2015;Oct 2.
[392] McLaren N. Primum pecunias multas faciamus. Niallmclaren.com 2024;Feb 27 and McLaren N. On urban myths. Niallmclaren.com 2024;May 14.
[393] Jorm AF, Korten AE, Jacomb PA, et al. "Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. Med J Aus 1997;166:182-6.
[394] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015.
[395] Videos from International meeting: Psychiatric drugs do more harm than good. Copenhagen 2015;Sept 16.
[396] Moynihan R, Cassels A. Selling Sickness: how the world's biggest pharmaceutical companies are turning us all into patients. New York: Nation Books; 2005.

[397] Behandling af obsessiv-kompulsiv tilstand (OCD). National klinisk retningslinje. København: Sundhedsstyrelsen; 2019.
[398] Haug TT, Blomhoff S, Hellstrøm K, et al. Exposure therapy and sertraline in social phobia: 1-year follow-up of a randomised controlled trial. Br J Psychiatry 2003;182:312–8.
[399] Bighelli I, Rodolico A, García-Mieres et al. Psychosocial and psychological interventions for relapse prevention in schizophrenia: a systematic review and network meta-analysis. Lancet Psychiatry 2021;8:969-80; McPherson S, Hengartner MP. Long-term outcomes of trials in the National Institute for Health and Care Excellence depression guideline. BJPsych Open 2019;5:e81; Spielmans GI, Berman MI, Usitalo AN. Psychotherapy versus second-generation antidepressants in the treatment of depression: a meta-analysis. J Nerv Ment Dis 2011;199:142–9; Cuijpers P, Hollon SD, van Straten A, et al. Does cognitive behaviour therapy have an enduring effect that is superior to keeping patients on continuation pharmacotherapy? A meta-analysis. BMJ Open 2013;26;3(4); Shedler J. The efficacy of psychodynamic psychotherapy. Am Psychol 2010;65:98-109; Furukawa TA, Shinohara K, Sahker E, et al. Initial treatment choices to achieve sustained response in major depression: a systematic review and network meta-analysis. World Psychiatry 2021;20:387-96; Amick HR, Gartlehner G, Gaynes BN, et al. Comparative benefits and harms of second generation antidepressants and cognitive behavioral therapies in initial treatment of major depressive disorder: systematic review and meta-analysis. BMJ 2015;351:h6019.
[400] James AC, James G, Cowdrey FA, et al. Cognitive behavioural therapy for anxiety disorders in children and adolescents. Cochrane Database Syst Rev 2015;2:CD004690.
[401] Boer PCAM, Wiersma D, Russo S, et al. Paraprofessionals for anxiety and depressive disorders. Cochrane Database Syst Rev 2005;2:CD004688.
[402] Dawes RM. House of cards. New York: The Free Press; 1994, page 54.
[403] Mayo-Wilson E, Montgomery P. Media-delivered cognitive behavioural therapy and behavioural therapy (selfhelp) for anxiety disorders in adults. Cochrane Database Syst Rev 2013;9:CD005330.
[404] Gava I, Barbui C, Aguglia E, et al. Psychological treatments versus treatment as usual for obsessive compulsive disorder (OCD). Cochrane Database Syst Rev 2007;2:CD005333.
[405] Soomro GM, Altman DG, Rajagopal S, et al. Selective serotonin re-uptake inhibitors (SSRIs) versus placebo for obsessive compulsive disorder (OCD). Cochrane Database Syst Rev 2008;1:CD001765.
[406] O'Kearney RT, Anstey KJ, von Sanden C. Behavioural and cognitive behavioural therapy for obsessive compulsive disorder in children and adolescents. Cochrane Database Syst Rev 2006;4:CD004856.
[407] Simonsen E, Møhl B (red.). Grundbog i psykiatri. København: Hans Reitzels Forlag; 2017.
[408] Behandling af obsessiv-kompulsiv tilstand (OCD). National klinisk retningslinje. København: Sundhedsstyrelsen; 2019.
[409] Mors O, Nordentoft M, Hageman I (red.). Klinisk psykiatri. København: Munksgaard; 2016.
[410] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015, page 295.
[411] Videbech P, Kjølbye M, Sørensen T, Vestergaard P (red.). Psykiatri. En lærebog om voksnes psykiske sygdomme. København: FADL's Forlag; 2018.
[412] Mors O, Nordentoft M, Hageman I (red.). Klinisk psykiatri. København: Munksgaard; 2016.
[413] FDA package insert for Lyrica (pregabalin).
[414] Broni B. En anden vinkel på antidepressiv medicin. OCD-foreningen 2014;Jan 28.
[415] Gøtzsche PC. Antidepressiv medicin bør undgås til børn og unge. OCD-nyt 2014;1:7.
[416] Mikkelsen LG. Lykkepiller som müslidrys. OCD-nyt 2014;Feb 1.
[417] Wield C. Doctors are not trained to think critically. Mad in America 2014;June 13.
[418] Gøtzsche PC. Psychiatry killed Tuva Andersson whose problem was anxiety. Mad in America 2023;July 8.
[419] Gøtzsche PC. Psychiatry killed Tuva Andersson whose problem was anxiety. Copenhagen: Institute for Scientific Freedom 2023;June 27.
[420] Schwartz LM, Woloshin S, Welch HG. Using a drug facts box to communicate drug benefits and harms: two randomized trials. Ann Intern Med 2009;150:516–27.
[421] Woloshin S, Schwartz LM, Welch HG. Know your Chances: understanding health statistics. Berkely: University of California Press; 2008.
[422] Woloshin S, Schwartz LM. Think inside the box. New York Times 2011;July 4.
[423] Winn D. Better to be human. Human Givens 2015:22:25-7.
[424] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 137.
[425] Whitely M. ADHD is BS. Video.
[426] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022.

[427] Timimi S. Insane medicine: How the mental health industry creates damaging treatment traps and how you can escape them. Seattle: Kindle Direct Publishing; 2021.
[428] Causes - Attention deficit hyperactivity disorder (ADHD). National Health Service 2021;Dec.
[429] Felholt L. Sådan lever voksne med skjult ADHD: 200.000 har det - kun få ved det. BT 2016;Feb 16.
[430] Gøtzsche PC. Fup og fakta om psykofarmaka. Deadly Medicines 2015;Feb 16.
[431] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 16 and Glessner JT, Li J, Wang D, et al. Copy number variation meta-analysis reveals a novel duplication at 9p24 associated with multiple neurodevelopmental disorders. Genome Med 2017;9:106.
[432] Wallach-Kildemoes H, Skovgaard AM, Thielen K, et al. Social adversity and regional differences in prescribing of ADHD medication for school-age children. J Dev Behav Pediatr 2015;36:330-41.
[433] Morrow RL, Garland EJ, Wright JM, et al. Influence of relative age on diagnosis and treatment of attention-deficit/hyperactivity disorder in children. CMAJ 2012;184:755-62.
[434] https://www.kidsskills.org/WP-fin/
[435] Adult ADHD Self-Report Scale-V1.1 (ASRS-V1.1) Symptoms Checklist from WHO Composite International Diagnostic Interview; 2003.
[436] Sørensen TK, Tycho G. En bemærkning fra sønnen fik Christina Stengel Finsen til at opsøge en psykiater. Jyllands-Posten 2024;April 14.
[437] Gøtzsche PC. How Danish journalism misleads about psychiatry: Multiple errors in a Danish newspaper article about adult ADHD. Mad in America 2024;April 30.
[438] Campanile C. Attention-deficit adults fail to get help. New York Post 2006;June 12.
[439] Breggin PR. The rights of children and parents in regard to children receiving psychiatric diagnoses and drugs. Children & Society 2014;28:231-41.
[440] Craine LS, Henson CE, Colliver JA, et al. Prevalence of a history of sexual abuse among female psychiatric patients in a state hospital system. Hosp Community Psychiatry 1988;39:300-4.
[441] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 16.
[442] Hoogman M, Bralten J, Hibar DP, et al. Subcortical brain volume differences in participants with attention deficit hyperactivity disorder in children and adults: a cross-sectional mega-analysis. Lancet Psychiatry 2017;4:310-9.
[443] Batstra L, Te Meerman S, Conners K, et al. Subcortical brain volume differences in participants with attention deficit hyperactivity disorder in children and adults. Lancet Psychiatry 2017;4:439.
[444] ADHD & the brain. The American Academy of Child and Adolescent Psychiatry 2017;Feb.
[445] Borg O. Pille-reklamer uddeles i skolegårde. Jyllands-Posten 2011;Nov 1.
[446] Reuben R, Elgaddal N. Attention-Deficit/Hyperactivity Disorder in children ages 5–17 years: United States, 2020–2022. CDC 2024;March and Xu G, Strathearn L, Liu B, et al. Twenty-year trends in diagnosed Attention-Deficit/Hyperactivity Disorder among US children and adolescents, 1997-2016. JAMA Netw Open 2018;1:e181471.
[447] Dastamooz S, Sadeghi-Bahmani D, Farahani MHD, et al. The efficacy of physical exercise interventions on mental health, cognitive function, and ADHD symptoms in children and adolescents with ADHD: an umbrella review. EClinicalMedicine 2023;62:102137.
[448] Borcherding BG, Keysor CS, Rapoport JL, et al. Motor/vocal tics and compulsive behaviors on stimulant drugs: is there a common vulnerability? Psychiatry Res 1990;33:83-94; Breggin P. The most dangerous thing you will ever do. Mad in America 2020;March 2; Breggin P. Psychiatric drug withdrawal: A guide for prescribers, therapists, patients and their families. New York: Springer; 2012; Breggin PR. The rights af children and parents in regard to children receiving psychiatric diagnoses and drugs. Children & Society 2014;28:231-41.
[449] The MTA Cooperative Group. A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. Arch Gen Psychiatry 1999;56:1073-86.
[450] Jensen PS, Arnold LE, Swanson JM, et al. 3-year follow-up of the NIMH MTA study. J Am Acad Child Adolesc Psychiatry 2007;46:989-1002.
[451] Molina BS, Flory K, Hinshaw SP, et al. Delinquent behavior and emerging substance use in the MTA at 36 months: prevalence, course, and treatment effects. J Am Acad Child Adolesc Psychiatry 2007;46:1028-40.
[452] Nadine Lambert. Wikipedia.
[453] Frost J. Ritalin may cause children to smoke early, abuse stimulants as adults, UC Berkeley professor says. University of California, Berkeley 1999;May 5.
[454] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015, page 306.

[455] Molina BS, Hinshaw SP, Swanson JM, et al. The MTA at 8 years: prospective follow-up of children treated for combined-type ADHD in a multisite study. J Am Acad Child Adolesc Psychiatry 2009;48:484-500.
[456] Sokal RF, Rohlf FJ. Biometry. New York: WH Freeman; 1981 and Armitage P, Berry G. Statistical methods in medical research. Oxford: Blackwell; 1971..
[457] Rasmussen MH, Andersen T, Breum L, Hilsted J, Gøtzsche PC. Observer variation in measurements of waist-hip ratio and the abdominal sagittal diameter. Int J Obes 1993;17:323-7.
[458] Miranda C. ADHD drugs could stunt growth. Daily Telegraph 2007;Nov 12.
[459] Vedantam S. Debate over drugs for ADHD reignites. Washington Post 2009;Mar 27.
[460] Gøtzsche PC. Deadly medicines and organised crime: How big pharma has corrupted health care. London: Radcliffe Publishing; 2013, page 156.
[461] Swanson JM, Arnold LE, Molina BSG, et al. Young adult outcomes in the follow-up of the multimodal treatment study of attention-deficit/hyperactivity disorder: symptom persistence, source discrepancy, and height suppression. J Child Psychol Psychiatry 2017;58:663-78.
[462] Breggin PR. Brain-disabling treatments in psychiatry: drugs, electroshock, and the psychopharmaceutical complex. New York: Springer; 2008.
[463] Kortegaard L. Lisbeth Kortegaard: Skyd budbringeren – om overforbrug af psykofarmaka. Ugeskr Læger 2014;Jan 21 and Ørum E, Tuxen KS. Psykiater: Børn med psykiske diagnoser har godt af at blive afmedicineret. DR 2014;April 22.
[464] Breggin PR. The rights af children and parents in regard to children receiving psychiatric diagnoses and drugs. Children & Society 2014;28:231-41.
[465] Cortese S, Coghill D, Mattingly GW, et al. WHO Model Lists of Essential Medicines: methylphenidate for ADHD in children and adolescents. Lancet Psychiatry 2023;10:743-4.
[466] Ponnou S, Timimi S, Briffault X, et al. WHO Essential Medicines List and methylphenidate for ADHD in children and adolescents. Lancet Psychiatry 2024;11:92-3.
[467] Boesen K, Juhl Jørgensen K, Gøtzsche PC. The US Food and Drug Administration's authorisation of Purdue's controlled-release methylphenidate for adult ADHD: comments on the regulatory practice. J R Soc Med 2021;114:377-80.
[468] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 127.
[469] Lopez PL, Torrente FM, Ciapponi A, et al. Cognitive-behavioural interventions for attention deficit hyperactivity disorder (ADHD) in adults. Cochrane Database Syst Rev 2018;3:CD010840.
[470] Boesen K, Saiz LC, Erviti J, et al. The Cochrane Collaboration withdraws a review on methylphenidate for adults with attention deficit hyperactivity disorder. Evid Based Med 2017;22:143-7.
[471] Storebø OJ, Ramstad E, Krogh HB, et al. Methylphenidate for children and adolescents with attention deficit hyperactivity disorder (ADHD). Cochrane Database Syst Rev 2015;11:CD009885 and Boesen K, Paludan-Müller AS, Gøtzsche PC, et al. Extended-release methylphenidate for attention deficit hyperactivity disorder (ADHD) in adults. Cochrane Database Syst Rev 2022;2:CD012857.
[472] Petersen M. Our daily meds. New York: Sarah Crichton Books; 2008 and Whitaker R. Anatomy of an epidemic. New York: Broadway Paperbacks; 2010.
[473] Boesen K, Jørgensen KJ, Gøtzsche PC. Clinical trials were missing from regulatory documents of extended-release methylphenidate for ADHD in adults: a case study of public documents. J Clin Epidemiol 2022;143:242-53.
[474] Connor DF, Glatt SJ, Lopez ID, et al. Psychopharmacology and aggression. I: A meta-analysis of stimulant effects on overt/covert aggression-related behaviors in ADHD. J Am Acad Child Adolesc Psychiatry 2002;41:253-61.
[475] Higgins JPT, Green S (eds.). Cochrane Handbook for Systematic Reviews of Interventions Version 5.1.0 [updated March 2011]. The Cochrane Collaboration 2011.
[476] Minutes of the Pediatric Advisory Committee. FDA 2006;Mar 22; Moore TJ, Glenmullen J, Furberg CD. Prescription drugs associated with reports of violence towards others. PLoS One 2010;5:e15337; FDA package insert for Ritalin (methylphenidate).
[477] Asherson P. Drug treatments for ADHD reduce risk of substance use disorders. Am J Psychiatry 2017;174:827-8.
[478] Faraone SV, Glatt SJ. A comparison of the efficacy of medications for adult attention-deficit/hyperactivity disorder using meta-analysis of effect sizes. J Clin Psychiatry 2010;71:754-63.
[479] Altman DG, Royston P. The cost of dichotomising continuous variables. BMJ 2006;332:1080.

[480] Dalsgaard S, Mortensen PB, Frydenberg M, et al. Long-term criminal outcome of children with attention deficit hyperactivity disorder. Crim Behav Ment Health 2013;23:86-98.
[481] Dalsgaard S, Mortensen PB, Frydenberg M, et al. ADHD, stimulant treatment in childhood and subsequent substance abuse in adulthood - a naturalistic long-term follow-up study. Addict Behav 2014;39:325-8.
[482] Danborg PB, Simonsen AL, Gøtzsche PC. Impaired reproduction after exposure to ADHD drugs: Systematic review of animal studies. Int J Risk Saf Med 2017;29:107-24.
[483] Boesen K, Paludan-Müller AS, Gøtzsche PC, et al. Extended-release methylphenidate for attention deficit hyperactivity disorder (ADHD) in adults. Cochrane Database Syst Rev 2022;2:CD012857.
[484] Ophir Y. Reconsidering the safety profile of stimulant medications for ADHD. Ethical Hum Psychol Psychiatry 2022;24:41-50.
[485] Storebø OJ, Pedersen N, Ramstad E, et al. Methylphenidate for attention deficit hyperactivity disorder (ADHD) in children and adolescents – assessment of adverse events in non-randomised studies. Cochrane Database Syst Rev 2018;5:CD012069.
[486] Shoptaw SJ, Kao U, Heinzerling K, et al. Treatment for amphetamine withdrawal. Cochrane Database Syst Rev 2009;2:CD003021.
[487] National Institutes of Health Consensus Development Conference Statement: diagnosis and treatment of attention-deficit/hyperactivity disorder (ADHD). J Am Acad Child Adolesc Psychiatry 2000:39:182-93.
[488] Breggin P. Psychiatric drug withdrawal: A guide for prescribers, therapists, patients and their families. New York: Springer; 2012; Cherland E, Fitzpatrick R. Psychotic side effects of psychostimulants: a 5-year review. Can J Psychiatry 1999;44:811-3; FDA package insert for Ritalin.
[489] FDA. Minutes of the Pediatric Advisory Committee. 2006;March 22.
[490] Mosholder AD, Gelperin K, Hammad TA, et al. Hallucinations and other psychotic symptoms associated with the use of attention-deficit/hyperactivity disorder drugs in children. Pediatrics 2009;123:611-6.
[491] FDA package insert for methylphenidate, extended release. Page 7.
[492] Boesen K, Paludan-Müller AS, Gøtzsche PC, et al. Extended-release methylphenidate for attention deficit hyperactivity disorder (ADHD) in adults. Cochrane Database Syst Rev 2022;2:CD012857, page 28 and Medicines Healthcare products Regulatory Agency. Public Assessment Report. Mutual Recognition Procedure. Concerta® XL 27 mg prolonged-release tablets (methylphenidate hydrochloride), UK/H/0544/004/MR. UK licence no: PL 00242/0400; July 2010 (updated November 2013), page 63.
[493] Moore TJ, Glenmullen J, Furberg CD. Prescription drugs associated with reports of violence towards others. PLoS One 2010;5:e15337.
[494] Gøtzsche PC. Another Vyvanse-assisted suicide in Florida foster care program, streamed live on Facebook. Deadly Medicines 2017;March 24.
[495] Psychiatric Drugging of Children is a "Crime Against Humanity" — Peter Gøtzsche, M.D. Medicating Normal video 2019;Sept 22.
[496] WHO. Management of substance abuse. Amphetamine-like substances. Undated (accessed 14 March 2020).
[497] What is the scope of methamphetamine misuse in the United States? National Institute on Drug Abuse 2019;Oct.
[498] EU Drug Market: Methamphetamine. European Monitoring Centre for Drugs and Drug Addiction, and Europol. Accessed 20 May 2024.
[499] FDA package insert for methamphetamine.
[500] FDA updating warnings to improve safe use of prescription stimulants used to treat ADHD and other conditions. FDA Drug Safety Communication 2023;May 11.
[501] Adams M. Neurologist Dr. Fred Baughman talks about the fraud of ADHD and the poisoning of U.S. children. Natural News 2006;Aug 30.
[502] Canada regulators order ADD drug withdrawn. Associated Press 2015;Feb 10.
[503] FDA package insert for Ritalin.
[504] Dalsgaard S, Kvist AP, Leckman JF, et al. Cardiovascular safety of stimulants in children with attention-deficit/hyperactivity disorder: a nationwide prospective cohort study. J Child Adolesc Psychopharmacol 2014;24:302-10.
[505] Minutes of the Pediatric Advisory Committee. FDA 2006;Mar 22; Moore TJ, Glenmullen J, Furberg CD. Prescription drugs associated with reports of violence towards others. PLoS One 2010;5:e15337; Gould MS, Walsh BT, Munfakh JL, et al. Sudden death and use of stimulant medications in youths. Am J Psychiatry. 2009 Sep;166(9):992-1001.

[506] Moore TJ, Glenmullen J, Furberg CD. Prescription drugs associated with reports of violence towards others. PLoS One 2010;5:e15337.
[507] Spence D. Bad medicine: adult attention-deficit/hyperactivity disorder. BMJ 2011;343:d7244.
[508] Carey B, Harris G. Psychiatric group faces scrutiny over drug industry ties. New York Times 2008;July 12.
[509] Aagaard L, Hansen EH. The occurrence of adverse drug reactions reported for attention deficit hyperactivity disorder (ADHD) medications in the pediatric population: a qualitative review of empirical studies. Neuropsychiatr Dis Treat 2011;7:729–44.
[510] Harris G. Research center tied to drug company. New York Times 2008;Nov 25.
[511] Joseph Biederman. Wikipedia (accessed 2 Feb 2024).
[512] Biederman J, Faraone S, Mick E, et al. Attention-deficit hyperactivity disorder and juvenile mania: an overlooked comorbidity? J Am Acad Child Adolesc Psychiatry 1996;35:997-1008.
[513] Whitaker R. Mad in America: bad science, bad medicine, and the enduring mistreatment of the mentally ill. Cambridge: Perseus Books Group; 2002.
[514] FDA package insert for Ritalin (methylphenidate).
[515] FDA package insert for Prozac (fluoxetine).
[516] Martin A, Young C, Leckman JF et al. Age effects on antidepressant-induced manic conversion. Arch Pediatr Adolesc Med 2004;158:773-80.
[517] Parry PI, Allison S, Bastiampillai T. Reification of the paediatric bipolar hypothesis in the USA. Lancet Psychiatry 2015;2:14-6.
[518] Kirk SA, Gomory T, Cohen D. Mad science: psychiatric coercion, diagnosis and drugs. New Brunswick: Transaction Publishers; 2013.
[519] Engmann J. Dagens menu for ligaens bedste: guld, champagne og en wienerschnitzel. Jyllands-Posten 2024;May 26:36.
[520] Moncrieff J, Cohen D, Mason JP. The subjective experience of taking antipsychotic medication: a content analysis of Internet data. Acta Psychiatr Scand 2009;120:102-11 and Read J, Williams J. Positive and negative effects of antipsychotic medication: an international online survey of 832 recipients. Curr Drug Saf 2019;14:173-81.
[521] Moncrieff J. The bitterest pills. Basingstoke: Palgrave Macmillan; 2013, page 46.
[522] Leucht S, Kane JM, Etschel E, et al. Linking the PANSS, BPRS, and CGI: clinical implications. Neuropsychopharmacology 2006;31:2318-25 and Khin NA, Chen YF, Yang Y, et al. Exploratory analyses of efficacy data from schizophrenia trials in support of new drug applications submitted to the US Food and Drug Administration. J Clin Psychiatry 2012;73:856–64.
[523] Stroup TS, McEvoy JP, Swartz MS, et al. The National Institute of Mental Health Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) project: schizophrenia trial design and protocol development. Schizophr Bull 2003;29:15-31.
[524] Manschreck TC, Boshes RA. The CATIE schizophrenia trial: results, impact, controversy. Harv Rev Psychiatry 2007;15:245-58.
[525] Dold M, Li C, Tardy M, et al. Benzodiazepines for schizophrenia. Cochrane Database Syst Rev 2012;11:CD006391.
[526] Zaman H, Sampson SJ, Beck AL, et al. Benzodiazepines for psychosis-induced aggression or agitation. Cochrane Database Syst Rev 2017;12:CD003079.
[527] Gøtzsche PC. Cochrane's demise: misleading denigration of benzodiazepines for acute psychosis. Mad in America 2023;June 3.
[528] Dold M, Li C, Tardy M, et al. Benzodiazepines for schizophrenia. Cochrane Database Syst Rev 2012;11:CD006391.
[529] Gøtzsche PC. Misleading denigration of benzodiazepines when compared to antipsychotics. Cochrane Database Syst Rev 2023;Jan 3.
[530] Gøtzsche PC. Cochrane reviews of psychiatric drugs are untrustworthy. Mad in America 2023;Sept 14.
[531] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 43.
[532] Whitaker R. Mad in America: bad science, bad medicine, and the enduring mistreatment of the mentally ill. Cambridge: Perseus Books Group; 2002, page 155; Moncrieff J. The myth of the chemical cure: a critique of psychiatric drug treatment. Basingstoke: Palgrave Macmillan; 2007, page 53; Kirk SA, Gomory T, Cohen D. Mad science: psychiatric coercion, diagnosis and drugs. New Brunswick: Transaction Publishers; 2013; Gronfein W. Psychotropic drugs and the origins of deinstitutionalization. Social Problems 1985;32:437-54.

[533] Bola J, Kao D, Soydan H, et al. Antipsychotic medication for early episode schizophrenia. Cochrane Database Syst Rev 2011;6:CD006374.
[534] Kirkpatrick B, Fenton WS, Carpenter WT Jr, et al. The NIMH-MATRICS consensus statement on negative symptoms. Schizophr Bull 2006;32:214-9.
[535] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015.
[536] Breggin P. Brain-disabling treatments in psychiatry: drugs, electroshock and the psychopharmaceutical complex. New York: Springer; 2007.
[537] Moncrieff J. Antipsychotic maintenance treatment: time to rethink? PLoS Med 2015;12:e1001861.
[538] Karon BP. All I know about Peter Breggin. In: The International Center for the Study of Psychiatry and Psychology. The Conscience of Psychiatry. The reform work of Peter R. Breggin, MD. New York: Lake Edge Press; 2009.
[539] Weiden PJ, Mann JJ, Haas G, et al. Clinical nonrecognition of neuroleptic-induced movement disorders: a cautionary study. Am J Psychiatry 1987;144:1148-53.
[540] Gøtzsche PC. Videos of tardive dyskinesia and akathisia. Institute for Scientific Freedom 2023;June 19; Gøtzsche PC. Psychiatry's denial of the horrors of tardive dyskinesia. Mad in America 2023;June 24; McCarter C. The death of Joey Marino. Mad in America 2024;April 26.
[541] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 65.
[542] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 59; Manschreck TC, Boshes RA. The CATIE schizophrenia trial: results, impact, controversy. Harv Rev Psychiatry 2007;15:245-58; Davis JM, Chen N, Glick ID. A meta-analysis of the efficacy of second-generation antipsychotics. Arch Gen Psychiatry 2003;60:553-64; Geddes J, Freemantle N, Harrison P, et al. Atypical antipsychotics in the treatment of schizophrenia: systematic overview and meta-regression analysis. BMJ 2000;321:1371-6; Leucht S, Corves C, Arbter D, et al. Second-generation versus first-generation antipsychotic drugs for schizophrenia: a meta-analysis. Lancet 2009;373:31–41; Tyrer P, Kendall T. The spurious advance of antipsychotic drug therapy. Lancet 2009;373:4–5.
[543] Insel T. Healing: our path from mental illness to mental health. New York: Penguin Press; 2022.
[544] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 61.
[545] Li CR, Chung YC, Park TW, et al. Clozapine-induced tardive dyskinesia in schizophrenic patients taking clozapine as a first-line antipsychotic drug. World J Biol Psychiatry 2009;10:919-24.
[546] Asenjo Lobos C, Komossa K, Rummel-Kluge C, et al. Clozapine versus other atypical antipsychotics for schizophrenia. Cochrane Database Syst Rev 2010;11:CD006633.
[547] Christensen DC. Dear Luise: a story of power and powerlessness in Denmark's psychiatric care system. Portland: Jorvik Press; 2012.
[548] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 53.
[549] Danborg PB, Gøtzsche PC. Benefits and harms of antipsychotic drugs in drug-naïve patients with psychosis: A systematic review. Int J Risk Saf Med 2019;30:193-201.
[550] Francey SM, O'Donoghue B, Nelson B, et al. Psychosocial intervention with or without antipsychotic medication for first episode psychosis: a randomized noninferiority clinical trial. Schizophr Bull Open 2020;Mar 20.
[551] Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022, page 33.
[552] Hughes S, Cohen D, Jaggi R. Differences in reporting serious adverse events in industry sponsored clinical trial registries and journal articles on antidepressant and antipsychotic drugs: a cross-sectional study. BMJ Open 2014;4:e005535.
[553] Schneider LS, Dagerman KS, Insel P. Risk of death with atypical antipsychotic drug treatment for dementia: metaanalysis of randomized placebo-controlled trials. JAMA 2005;294:1934-43.
[554] FDA package insert for Risperdal.
[555] Samara MT, Klupp E, Helfer B, et al. Increasing antipsychotic dose for non response in schizophrenia. Cochrane Database Syst Rev 2018;5:CD011883 and Davis JM, Chen N, Glick ID. A meta-analysis of the efficacy of second-generation antipsychotics. Arch Gen Psychiatry 2003;60:553-64.
[556] Forbruget af antipsykotika blandt 18-64 årige patienter, med skizofreni, mani eller bipolar affektiv sindslidelse. København: Sundhedsstyrelsen; 2006.
[557] Hallas J. Brug af flere antipsykotika samtidig og risikoen for død. Ugeskr Læger 2007;169:618.
[558] Baandrup L, Gasse C, Jensen VD, et al. Antipsychotic polypharmacy and risk of death from natural causes in patients with schizophrenia: a population-based nested case-control study. J Clin Psychiatry 2010;71:103-8.

[559] Gøtzsche PC. Polyfarmaci med antipsykotika øger dødeligheden. Ugeskr Læger 2016;178:397.
[560] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 46.
[561] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 172.
[562] Gøtzsche PC. Neuroleptika øger dødeligheden. Deadly Medicines 2018;Feb 18.
[563] Gøtzsche PC. Psychiatry ignores an elephant in the room. Mad in America 2017;Sept 21.
[564] Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022, page 40.
[565] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, pages 163 and 234.
[566] Gøtzsche PC. Robotic rejections of relevant letters to the editor of World Psychiatry. Copenhagen: Institute for Scientific Freedom 2023;June 6.
[567] Wils RS, Gotfredsen DR, Hjorthøj C, et al. Antipsychotic medication and remission of psychotic symptoms 10 years after a first-episode psychosis. Schizophr Res 2017;182:42-8.
[568] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022.
[569] Hjorthøj CR, Madsen T, Agerbo E, et al. Risk of suicide according to level of psychiatric treatment: a nationwide nested case-control study. Soc Psychiatry Psychiatr Epidemiol 2014;49:1357-65.
[570] Large MM, Ryan CJ. Disturbing findings about the risk of suicide and psychiatric hospitals. Soc Psychiatry Psychiatr Epidemiol 2014;49:1353-5.
[571] Gøtzsche PC. Death of a whistleblower and Cochrane's moral collapse. Copenhagen: People's Press; 2019 and Gøtzsche PC. Decline and fall of the Cochrane empire. Copenhagen: Institute for Scientific Freedom; 2022. Freely available.
[572] Varese F, Smeets F, Drukker M, et al. Childhood adversities increase the risk of psychosis: a meta-analysis of patient-control, prospective- and cross-sectional cohort studies. Schizophr Bull 2012;38:661-71 and Shevlin M, Houston JE, Dorahy MJ, Adamson G. Cumulative traumas and psychosis: an analysis of the national comorbidity survey and the British Psychiatric Morbidity Survey. Schizophr Bull 2008;34:193-9.
[573] Gøtzsche PC. Death of a whistleblower and Cochrane's moral collapse. Copenhagen: People's Press; 2019 and Gøtzsche PC. Decline and fall of the Cochrane empire. Copenhagen: Institute for Scientific Freedom; 2022. Freely available.
[574] Thorat R. Reply to: Bastian H. Scientific advocacy and biases of the ideological and industry kinds. 2018;Sept 28.
[575] Pedersen AT. Diagnosing psychiatry. Documentary film 2017.
[576] Pedersen AT. En psykiatrisk diagnose hænger ved resten af livet. PsykiatriAvisen 2019;Jan 18.
[577] Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022, page 145.
[578] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022.
[579] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 50.
[580] Read J. A history of madness. In: Read J, Dillon J, eds. Models of madness, 2nd ed. London: Routledge; 2013.
[581] Seikkula J, AaltonenJ, Alakare B, et al. Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. Psychotherapy Research 2006;16:214-28 and Svedberg B, Mesterton A, Cullberg J. First-episode non-affective psychosis in a total urban population: a 5-year follow-up. Soc Psychiatry Psychiatr Epidemiol 2001;36:332-7.
[582] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 330.
[583] Whitaker R. Mad in America: bad science, bad medicine, and the enduring mistreatment of the mentally ill. Cambridge: Perseus Books Group; 2002.
[584] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015.
[585] Røssberg JI. Det finnes ikke veldokumenterte behandlingsmetoder uten bruk av medikamenter for personer med psykotiske lidelser. Aftenposten 2016;June 13.
[586] Gøtzsche PC. Medisinfrie alternativer virker på psykose. Aftenposten 2016;June 27 and Gøtzsche PC. Medicinfri psykiatri. Tidsskr Nor Laegeforen 2017;Oct 17.
[587] Røssberg JI. Er medisinfrie soner et nødvendig skille eller konstruert polarisering? Aftenposten 2016;July 4:19.
[588] Malt UF. Behandling av psykoser. Aftenposten 2016;July1:22.
[589] Sørensen J-M. Professorer som sprer frykt, halvsannheter og løgn. Aftenposten 2016;Aug 25:21.
[590] Psychosis and schizophrenia in adults: prevention and management. Clinical guideline [CG178]. NICE 2014;Feb 12.
[591] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 51.

[592] Kinoshita Y, Furukawa TA, Kinoshita K, et al. Supported employment for adults with severe mental illness. Cochrane Database Syst Rev 2013;9:CD008297.
[593] Bighelli I, Rodolico A, García-Mieres et al. Psychosocial and psychological interventions for relapse prevention in schizophrenia: a systematic review and network meta-analysis. Lancet Psychiatry 2021;8:969-80.
[594] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 51.
[595] Duncan E, Best C, Hagen S. Shared decision making interventions for people with mental health conditions. Cochrane Database Syst Rev 2010;1:CD007297.
[596] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 333.
[597] Stemningsstabiliserende medicin. Psykiatrien i Region Midtjylland 2022;Jan.
[598] Börjesson J, Gøtzsche PC. Effect of lithium on suicide and mortality in mood disorders: A systematic review. Int J Risk Saf Med 2019;30:155-66.
[599] Videbech P, Kjølbye M, Sørensen T, Vestergaard P (red.). Psykiatri. En lærebog om voksnes psykiske sygdomme. København: FADL's Forlag; 2018, page 241.
[600] Leucht S, Helfer B, Dold M, et al. Lithium for schizophrenia. Cochrane Database Syst Rev 2015;10:CD003834.
[601] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 106.
[602] FDA package insert for Neurontin.
[603] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 192.
[604] Ghaemi SN. The failure to know what isn't known: negative publication bias with lamotrigine and a glimpse inside peer review. Evid Based Ment Health 2009;12:65-8
[605] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 112.
[606] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 144.
[607] Gøtzsche PC. Demensmedicin bremser ikke sygdomsudvikling. Jyllands-Posten 2022;Nov 1.
[608] Birks J. Cholinesterase inhibitors for Alzheimer's disease. Cochrane Database Syst Rev 2006;1:CD005593.
[609] Molnar FJ, Man-Son-Hing M, Fergusson D. Systematic review of measures of clinical significance employed in randomized controlled trials of drugs for dementia. J Am Geriatr Soc 2009;57:536-46.
[610] FDA package insert for Aricept (donepezil).
[611] Syncope with cholinesterase inhibitors. Rev Prescrire 2011;31:434.
[612] Tjia J, Briesacher BA, Peterson D, et al. Use of medications of questionable benefit in advanced dementia. JAMA Intern Med 2014;174:1763-71.
[613] Screening for dementia. UK National Screening Committee 2014;April.
[614] Courtney C, Farrell D, Gray R, et al. Long-term donepezil treatment in 565 patients with Alzheimer's disease (AD2000): randomised double-blind trial. Lancet 2004;363:2105-15.
[615] Letter from Sharon M. Watson to Eisai Medical Research Inc. FDA 2010;Feb 3.
[616] Gøtzsche PC. Death of a whistleblower and Cochrane's moral collapse. Copenhagen: People's Press; 2019 and Gøtzsche PC. Decline and fall of the Cochrane empire. Copenhagen: Institute for Scientific Freedom; 2022. Freely available.
[617] Battle CE, Abdul-Rahim AH, Shenkin SD, et al. Cholinesterase inhibitors for vascular dementia and other vascular cognitive impairments: a network meta-analysis. Cochrane Database Syst Rev 2021;2:CD013306.
[618] Street JS, Clark WS, Gannon KS, et al. Olanzapine treatment of psychotic and behavioral symptoms in patients with Alzheimer disease in nursing care facilities: a double-blind, randomized, placebo-controlled trial. The HGEU Study Group. Arch Gen Psychiatry 2000;57:968-76.
[619] Breggin P. Psychiatric drug withdrawal: A guide for prescribers, therapists, patients and their families. New York: Springer; 2012 and Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015.
[620] Saczynski JS, Beiser A, Seshadri S, et al. Depressive symptoms and risk of dementia: the Framingham Heart Study. Neurology 2010;75:35-41.
[621] Billioti de Gage S, Moride Y, Ducruet T, et al. Benzodiazepine use and risk of Alzheimer's disease: case-control study. BMJ 2014;349:g5205.
[622] Livingston G, Kelly L, Lewis-Holmes E, et al. Non-pharmacological interventions for agitation in dementia: systematic review of randomised controlled trials. Br J Psychiatry 2014;205:436-42.
[623] Gøtzsche PC. Medicin mod Alzheimer virker ikke. Ugeskr Læger 2017;May 8.
[624] Drugs for Alzheimer's Disease. Therapeutics Initiative, University of British Columbia 2005;Aug 31.
[625] Whitaker R. Mad in America: bad science, bad medicine, and the enduring mistreatment of the mentally ill. Cambridge: Perseus Books Group; 2002, page 96.

[626] Whitaker R. Mad in America: bad science, bad medicine, and the enduring mistreatment of the mentally ill. Cambridge: Perseus Books Group; 2002, page 102.
[627] Breggin PR. Brain-disabling treatments in psychiatry: drugs, electroshock, and the psychopharmaceutical complex. New York: Springer; 2008.
[628] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 148.
[629] Read J, Bentall R. The effectiveness of electroconvulsive therapy: a literature review. Epidemiol Psichiatr Soc 2010 Oct-Dec;19:333-47; Carney S, Geddes J. Electroconvulsive therapy. BMJ 2003;326:1343-4; Rose D, Fleischmann P, Wykes T, et al. Patients' perspectives on electroconvulsive therapy: systematic review. BMJ 2003;326:1363; Read J, Moncrieff J. Depression: why drugs and electricity are not the answer. Psychological Medicine 2022; Febr 1:1–10; Frandsen P. Et anker af flamingo: Det, vi glemmer, gemmer vi i hjertet. Odense: Mellemgaard; 2019.
[630] Rose D, Fleischmann P, Wykes T, et al. Patients' perspectives on electroconvulsive therapy: systematic review. BMJ 2003;326:1363.
[631] UK ECT Review Group. Efficacy and safety of electroconvulsive therapy in depressive disorders: a systematic review and meta-analysis. Lancet 2003;361:799-808.
[632] Read J, Bentall R. The effectiveness of electroconvulsive therapy: a literature review. Epidemiol Psichiatr Soc 2010 Oct-Dec;19:333-47.
[633] UK ECT Review Group. Efficacy and safety of electroconvulsive therapy in depressive disorders: a systematic review and meta-analysis. Lancet 2003;361:799-808 and Read J, Bentall R. The effectiveness of electroconvulsive therapy: a literature review. Epidemiol Psichiatr Soc 2010 Oct-Dec;19:333-47.
[634] Read J. A response to yet another defence of ECT in the absence of robust efficacy and safety evidence. Epidemiol Psychiatr Sci 2022;31:e13.
[635] UK ECT Review Group. Efficacy and safety of electroconvulsive therapy in depressive disorders: a systematic review and meta-analysis. Lancet 2003;361:799-808.
[636] Munkholm K, Jørgensen KJ, Paludan-Müller AS. Electroconvulsive therapy for preventing relapse and recurrence in people with depression (Protocol). Cochrane Database Syst Rev 2022:1:CD015164.
[637] Tharyan P, Adams CE. Electroconvulsive therapy for schizophrenia. Cochrane Database Syst Rev 2005;2:CD000076.
[638] Rose D, Fleischmann P, Wykes T, et al. Patients' perspectives on electroconvulsive therapy: systematic review. BMJ 2003;326:1363.
[639] Frandsen P. Et anker af flamingo: Det, vi glemmer, gemmer vi i hjertet. Odense: Mellemgaard; 2019.
[640] Van der Wurff FB, Stek ML, Hoogendijk WL, et al. Electroconvulsive therapy for the depressed elderly. Cochrane Database Syst Rev 2003;2:CD003593.
[641] Klinisk vejledning for almen praksis: unipolar depression, diagnostik og behandling. Dansk Selskab for Almen Medicin 2010.
[642] Rose D, Fleischmann P, Wykes T, et al. Patients' perspectives on electroconvulsive therapy: systematic review. BMJ 2003;326:1363; UK ECT Review Group. Efficacy and safety of electroconvulsive therapy in depressive disorders: a systematic review and meta-analysis. Lancet 2003;361:799-808; Read J, Bentall R. The effectiveness of electroconvulsive therapy: a literature review. Epidemiol Psichiatr Soc 2010 Oct-Dec;19:333-47.
[643] Frich M. Brug af elektrochok firedoblet. Jyllands-Posten 1998;May 19.
[644] Borre K. Mette's Voice. Documentary film 2014.
[645] Gøtzsche PC. Chemical or psychological psychotherapy? Mad in America 2017;Jan 29.
[646] Breggin PR. Intoxication anosognosia: the spellbinding effect of psychiatric drugs. Ethical Hum Psychol Psychiatry 2006;8:201–15.
[647] Bighelli I, Rodolico A, García-Mieres et al. Psychosocial and psychological interventions for relapse prevention in schizophrenia: a systematic review and network meta-analysis. Lancet Psychiatry 2021;8:969-80; McPherson S, Hengartner MP. Long-term outcomes of trials in the National Institute for Health and Care Excellence depression guideline. BJPsych Open 2019;5:e81; Spielmans GI, Berman MI, Usitalo AN. Psychotherapy versus second-generation antidepressants in the treatment of depression: a meta-analysis. J Nerv Ment Dis 2011;199:142–9; Cuijpers P, Hollon SD, van Straten A, et al. Does cognitive behaviour therapy have an enduring effect that is superior to keeping patients on continuation pharmacotherapy? A meta-analysis. BMJ Open 2013;26;3(4); Shedler J. The efficacy of psychodynamic psychotherapy. Am Psychol 2010;65:98-109; Furukawa TA, Shinohara K, Sahker E, et al. Initial treatment choices to achieve sustained response in major depression: a systematic review and network meta-analysis. World Psychiatry 2021;20:387-96; Amick HR, Gartlehner G, Gaynes BN, et al. Comparative benefits and harms of second generation

antidepressants and cognitive behavioral therapies in initial treatment of major depressive disorder: systematic review and meta-analysis. BMJ 2015;351:h6019.
[648] Furukawa TA, Shinohara K, Sahker E, et al. Initial treatment choices to achieve sustained response in major depression: a systematic review and network meta-analysis. World Psychiatry 2021;20:387-96.
[649] Gøtzsche PC. Psychotherapy has an enduring effect on depression—in contrast to depression pills. Mad in America 2021;Nov 23.
[650] Hengartner MP, Plöderl M. Newer-generation antidepressants and suicide risk in randomized controlled trials: a re-analysis of the FDA database. Psychother Psychosom 2019;88:247-8 and Hengartner MP, Plöderl M. Reply to the Letter to the Editor: "Newer-Generation Antidepressants and Suicide Risk: Thoughts on Hengartner and Plöderl's Re-Analysis." Psychother Psychosom 2019;88:373-4.
[651] Gøtzsche PC, Gøtzsche PK. Cognitive behavioural therapy halves the risk of repeated suicide attempts: systematic review. J R Soc Med 2017;110:404-10.
[652] Krupnick JL, Sotsky SM, Simmens S, et al. The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. J Consult Clin Psychol 1996;64:532–9.
[653] Demyttenaere K, Donneau A-F, Albert A, et al. What is important in being cured from: Does discordance between physicians and patients matter? (2). J Affect Disord 2015;174:372–7.
[654] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015.
[655] Nilsonne Å. Processen: möten, mediciner, beslut. Stockholm: Natur & Kultur; 2017.
[656] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 303.
[657] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015.
[658] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015, page 316.
[659] Thomsen PH, Rask CU, Bilenberg N (red.). Børne- og ungdomspsykiatri. København: FADLs Forlag; 2019.
[660] Starrfelt R, Gerlach C, Gade A (red.). Klinisk neuropsykologi. København: Frydenlund; 2021.
[661] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 18.
[662] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 124.
[663] Priest RG, Vize C, Roberts A, et al. Lay people's attitudes to treatment of depression: results of opinion poll for Defeat Depression Campaign just before its launch. BMJ 1996;313:858-9.
[664] Stubbe DE, Thomas WT. A survey of early-career child and adolescent psychiatrists: professional activities and perceptions. J Am Acad Child Adolesc Psychiatry 2002;41:123–30.
[665] Cooper M. Psychiatrist: Over diagnosis leads to strain on resources. KPLC 7 News 2014;Nov 27.
[666] Heldmark T. Alternativ behandling mot depression används för lite. Sveriges Radio 2020;Aug 24.
[667] Colom F, Vieta E, Martinez-Aran A, et al. A randomized trial on the efficacy of group psychoeducation in the prophylaxis of recurrences in bipolar patients whose disease is in remission. Arch Gen Psychiatry 2003;60:402-7.
[668] Mors O, Nordentoft M, Hageman I (red.). Klinisk psykiatri. København: Munksgaard; 2016, page 597.
[669] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015, page 8.
[670] Churchill R, Hunot V, Corney R, et al. A systematic review of controlled trials of the effectiveness and cost-effectiveness of brief psychological treatments for depression. Health Technol Assess 2001;5(35).
[671] Sørensen A. Withdrawing from antidepressants. PhD thesis. University of Copenhagen. Defended 2022;June 9.
[672] Gøtzsche PC, Gøtzsche PK. Cognitive behavioural therapy halves the risk of repeated suicide attempts: systematic review. J R Soc Med 2017;110:404-10.
[673] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 116.
[674] Turri MG. The best kept secret in psychiatry. Asylum Magazine 2019;26(2).
[675] Turri MG, Merson S, McNab S, Cooper RE. The Systemic Assessment Clinic, a novel method for assessing patients in general adult psychiatry: presentation and preliminary service evaluation. Community Mental Health Journal 2021;57:753-63.
[676] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 152.
[677] United Nations Convention on the Rights of Persons with Disabilities: General comment No. 1. 2014;May 19.
[678] Whitaker R. Mad in America: bad science, bad medicine, and the enduring mistreatment of the mentally ill. Cambridge: Perseus Books Group; 2002, page 106.
[679] Moore TJ, Glenmullen J, Furberg CD. Prescription drugs associated with reports of violence towards others. PLoS One 2010;5:e15337 and Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015.

[680] Fiorillo A, De Rosa C, Del Vecchio V, et al. How to improve clinical practice on involuntary hospital admissions of psychiatric patients: Suggestions from the EUNOMIA study. Eur Psychiat 2011;26:201-7 and Scanlan JN. Interventions to reduce the use of seclusion and restraint in inpatient psychiatric settings: what we know so far, a review of the literature. Int J Soc Psychiat 2010;56:412–23.
[681] Ryn ZJ. Rhythm of death: The experience of survivors of Nazi German concentrations camps. Medycyna Praktyczna, Krakow; 2018; German crimes in Poland. Warsaw; Central Commission for Investigation of German Crimes in Poland; 1946; Auschwitz: Nazi extermination camp. Warsaw: Interpress; 1978.
[682] Gøtzsche PC. Patienter mødes af ulovligt krav om at tage psykofarmaka for at modtage sociale ydelser. Jyllands-Posten 2022;April 8.
[683] Kisely SR, Campbell LA, O'Reilly R. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. Cochrane Database Syst Rev 2017;3:CD004408.
[684] Wollaston S. Community treatment orders are not helping people with mental illness. The Guardian 2013;Aug 14.
[685] Community treatment orders. Mind 2007;Dec.
[686] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 328.
[687] Fiorillo A, De Rosa C, Del Vecchio V, et al. How to improve clinical practice on involuntary hospital admissions of psychiatric patients: Suggestions from the EUNOMIA study. Eur Psychiat 2011;26:201-7.
[688] Steinert T, Lepping P, Bernhardsgrütter R, et al. Incidence of seclusion and restraint in psychiatric hospitals: a literature review and survey of international trends. Soc Psychiatry Psychiatr Epidemiol 2010;45:889-97.
[689] Christensen DC. Dear Luise: a story of power and powerlessness in Denmark's psychiatric care system. Portland: Jorvik Press; 2012.
[690] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 337.
[691] Nilsonne Å. Processen: möten, mediciner, beslut. Stockholm: Natur & Kultur; 2017.
[692] Zinkler M, von Peter S. End coercion in mental health services - toward a system based on support only. Laws 2019;8:19.
[693] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 328 and Gøtzsche PC. Forced drugging with antipsychotics is against the law: decision in Norway. Mad in America 2019;May 4.
[694] Gøtzsche PC, Vinther S, Sørensen A. Forced medication in psychiatry: Patients' rights and the law not respected by Appeals Board in Denmark. Clin Neuropsychiatry 2019;16:229-33 and Gøtzsche PC, Sørensen A. Systematic violations of patients' rights and safety: Forced medication of a cohort of 30 patients. Ind J Med Ethics 2020;Oct-Dec;5(4) NS:312-8.
[695] Dold M, Li C, Tardy M, et al. Benzodiazepines for schizophrenia. Cochrane Database Syst Rev 2012;11:CD006391.
[696] Tasch G, Gøtzsche PC. Systematic violations of patients' rights and safety: forced medication of a cohort of 30 patients in Alaska. Psychosis 2023;15:145-54.
[697] Christensen DC. Dear Luise: a story of power and powerlessness in Denmark's psychiatric care system. Portland: Jorvik Press; 2012; Frandsen P. Et anker af flamingo: Det, vi glemmer, gemmer vi i hjertet. Odense: Mellemgaard; 2019; Gøtzsche PC, Sørensen A. Systematic violations of patients' rights and safety: Forced medication of a cohort of 30 patients. Ind J Med Ethics 2020;Oct-Dec;5(4) NS:312-8;
[698] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 329.
[699] Oute J, McPherson S. Conflict and antagonism within global psychiatry: A discourse analysis of organisational responses to the UN reports on rights-based approaches in mental health. Sociology of Health & Illness 2024;46:473–94.
[700] World Health Organization & United Nations' Office of the High Commissioner for Human Rights. Mental health, human rights and legislation: guidance and practice. 2023;Oct 9.
[701] McLaren N. The new WHO and UN Guidance: Psychiatry must entirely change. Mad in America 2013;Nov 18.
[702] Gøtzsche PC. A remarkable feat: a psychiatric patient changed the law on restraints. Mad in America 2023;Dec 5.
[703] Gottstein J. The Zyprexa papers. Anchorage: Jim Gottstein; 2020.
[704] Gøtzsche PC, Jensen KB. Tvang i psykiatrien bør forbydes. Politikens kronik 2015;Aug 5; Gøtzsche PC, Jensen KB. Tvang i psykiatri bør forbydes. Dagens Medicin 2015;Sept 11; Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015; Gøtzsche PC. Abolishing forced treatment in psychiatry is an ethical imperative. Mad in America 2016;17 June; Dr. Peter Gøtzsche: Forced psychiatric treatment must be abolished.

Transcript of lecture in Anchorage and video 2016;June 2; Gøtzsche PC. Tvangslovene i psykiatrien skal afskaffes. P - Psykologernes Fagmagasin 2016;Mar 17; Gøtzsche PC, Lund K. Tvangsmedisinering må forbys. Kritisk Juss 2016;2:118-57; Gøtzsche PC. Forced drugging with antipsychotics is against the law: decision in Norway. Mad in America 2019;May 4; Gøtzsche PC, Lund K. Intet kunnskapsgrunnlag for tvangsmedisinering. In: Kolstad A, Kogstad R, eds. Medikalisering av psykososciale problemer. Oslo: Abstrakt Forlag; 2019: 175-210; Gøtzsche PC. Norsk ombudsmand har afgjort, at tvangsmedicinering ikke kan begrundes. Psykiatriavisen 2019;Jan 27; Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022; Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022;.

[705] Gottstein J, Gøtzsche PC, Cohen D, Ruby C, Myers F. Report on improving mental health outcomes. Psychrights 2023:Sept.

[706] Malt UF. Ubehandlet psykose øker risiko for helseskade. Aftenposten 2019;June 20.

[707] Gøtzsche PC. Svar til Malt: Ubehandlet psykose øker risiko for helseskade. Aftenposten 2019;June 20.

[708] Read J, Cartwright C, Gibson K. How many of 1829 antidepressant users report withdrawal effects or addiction? Int J Ment Health Nurs 2018;27:1805-15.

[709] Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022, page 115.

[710] Nielsen M, Hansen EH, Gøtzsche PC. What is the difference between dependence and withdrawal reactions? A comparison of benzodiazepines and selective serotonin re-uptake inhibitors. Addict 2012;107:900-8.

[711] Horowitz MA, Taylor D. Tapering of SSRI treatment to mitigate withdrawal symptoms. Lancet Psychiatry 2019;6:538-46.

[712] Rosenbaum JF, Fava M, Hoog SL, et al. Selective serotonin reuptake inhibitor discontinuation syndrome: a randomised clinical trial. Biol Psychiatry 1998;44:77-87.

[713] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, pages 114-5.

[714] Lewinsohn PM, Clarke GN, Seeley, et al. Major depression in community adolescents: age at onset, episode duration, and time to recurrence. J Am Acad Child Adolesc Psychiatr 1994;33:809-18.

[715] Davies J, Read J. A systematic review into the incidence, severity and duration of antidepressant withdrawal effects: Are guidelines evidence-based? Addict Behav 2019;97:111-21.

[716] Bawden A. Antidepressant withdrawal symptoms experienced by 15% of users, study finds. The Guardian 2024;June 6.

[717] Henssler J, Schmidt Y, Schmidt U, et al. Incidence of antidepressant discontinuation symptoms: a systematic review and meta-analysis. Lancet Psychiatry 2024;11:526-35.

[718] Pariante CM. The myth that antidepressants are addictive has been debunked – they are a vital tool in psychiatry. The Guardian 2024;June 6.

[719] Read J, Davies J. Why we are sceptical about this study of antidepressant withdrawal symptoms. The Guardian 2024;June 14.

[720] Council for Evidence-based Psychiatry.

[721] Nutt DJ, Goodwin GM, Bhugra D, et al. Attacks on antidepressants: signs of deep-seated stigma? Lancet Psychiatry 2014;1:103–4 and Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 16.

[722] Gøtzsche PC. Why I think antidepressants cause more harm than good. Lancet Psychiatry 2014;1:104-6.

[723] Davies J, Read J. A systematic review into the incidence, severity and duration of antidepressant withdrawal effects: Are guidelines evidence-based? Addict Behav 2019;97:111-21.

[724] Gøtzsche PC. Prescription pills are Britain's third biggest killer: Side-effects of drugs taken for insomnia and anxiety kill thousands. Why do doctors hand them out like Smarties? Daily Mail 2015;Sept 15.

[725] Response: Prescription pills kill. Press release, Royal College of Psychiatry 2015;Sept 15.

[726] Bero L, Farquhar C, Wilson M, Tovey D. Statement from Cochrane 2015;Sept 18.

[727] Gøtzsche PC. Cochrane reviews of psychiatric drugs are untrustworthy. Mad in America 2023;Sept 14.

[728] Melander H, Ahlqvist-Rastad J, Meijer G, et al. Evidence b(i)ased medicine – selective reporting from studies sponsored by pharmaceutical industry: review of studies in new drug applications. BMJ 2003;326:1171–3; Turner EH, Matthews AM, Linardatos E, et al. Selective publication of antidepressant trials and its influence on apparent efficacy. N Engl J Med 2008;358:252-60; Le Noury J, Nardo JM, Healy D, et al. Restoring Study 329: efficacy and harms of paroxetine and imipramine in treatment of major depression in adolescence. BMJ 2015;351:h4320; Sharma T, Guski LS, Freund N, et al. Suicidality and aggression during antidepressant treatment: systematic review and meta-analyses based on clinical study reports. BMJ 2016;352:i65; Maund E, Guski LS, Gøtzsche PC. Considering benefits and harms of duloxetine for treatment of stress urinary

incontinence: a meta-analysis of clinical study reports. CMAJ 2017;189:E194-203; Maund E, Tendal B, Hróbjartsson A, Jørgensen KJ, Lundh A, Schroll J, Gøtzsche PC. Benefits and harms in clinical trials of duloxetine for treatment of major depressive disorder: comparison of clinical study reports, trial registries, and publications. BMJ 2014;348:g3510; Sharma T, Guski LS, Freund N, et al. Drop-out rates in placebo-controlled trials of antidepressant drugs: A systematic review and meta-analysis based on clinical study reports. Int J Risk Saf Med 2019;30:217-32; Hengartner MP, Plöderl M. Newer-generation antidepressants and suicide risk in randomized controlled trials: a re-analysis of the FDA database. Psychother Psychosom 2019;88:247-8; Hengartner MP, Plöderl M. Reply to the Letter to the Editor: "Newer-Generation Antidepressants and Suicide Risk: Thoughts on Hengartner and Plöderl's ReAnalysis." Psychother Psychosom 2019;88:373-4; Gøtzsche PC, Healy D. Restoring the two pivotal fluoxetine trials in children and adolescents with depression. Int J Risk Saf Med 2022;33:385-408.

[729] Hughes S, Cohen D, Jaggi R. Differences in reporting serious adverse events in industry sponsored clinical trial registries and journal articles on antidepressant and antipsychotic drugs: a cross-sectional study. BMJ Open 2014;4:e005535.

[730] Wise J. Cochrane distances itself from controversial views on psychiatric drugs. BMJ 2015;351:h5073.

[731] Gøtzsche PC. Death of a whistleblower and Cochrane's moral collapse. Copenhagen: People's Press; 2019.

[732] Simons P. Peer-support groups were right, guidelines were wrong: Dr. Mark Horowitz on tapering off antidepressants. Mad in America 2019;Mar 20.

[733] Guy A, Davies J, Rizq R (eds.) Guidance for psychological therapists: Enabling conversations with clients taking or withdrawing from prescribed psychiatric drugs. London: APPG for Prescribed Drug Dependence; 2019:Dec.

[734] Psychiatric drug withdrawal / Udtrapning af psykofarmaka.

[735] Gøtzsche PC, Runcimann O, Bækgaard J, Sørensen A, Toft BS. Skru ned for psykofarmaka. Piller er ikke løsningen. Politikens kronik 2019;Sept 8.

[736] Gøtzsche PC, Runcimann O, Bækgaard J, Sørensen A, Toft BS. The epidemic of psychiatric drug usage – taper off the pills. Deadly Medicines 2019;Oct 22.

[737] International Institute for Psychiatric Drug Withdrawal.

[738] Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022 (first published on my website in 2020).

[739] Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Mad in America 2021.

[740] Institute for Scientific Freedom.

[741] Horowitz M, Taylor DM. The Maudsley Deprescribing Guidelines: Antidepressants, Benzodiazepines, Gabapentinoids and Z-drugs. London: Wiley-Blackwell; 2024.

[742] Breggin P. Medication madness. New York: St. Martin's Griffin; 2008.

[743] Gatenby A. "My anti-depressant withdrawal was worse than depression." BBC 2020; Mar 12.

[744] Groot P, van Os J. Antidepressant tapering strips to help people come off medication more safely. Psychosis 2018;10:142-5.

[745] Gøtzsche PC. Withdrawing from psychiatric drugs: How to produce smaller doses than those the drug companies provide. Mad in America 2023;Nov 21.

[746] Breggin P. Psychiatric drug withdrawal: A guide for prescribers, therapists, patients and their families. New York: Springer; 2012.

[747] Simons P. Peer-support groups were right, guidelines were wrong: Dr. Mark Horowitz on tapering off antidepressants. Mad in America 2019;Mar 20.

[748] Gøtzsche PC. Surviving psychiatry: a typical case of serious psychiatric drug harms. Mad in America 2020;Jan 7.

[749] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015.

[750] Breggin P. Psychiatric drug withdrawal: A guide for prescribers, therapists, patients and their families. New York: Springer; 2012 and Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022; Horowitz M, Taylor DM. The Maudsley Deprescribing Guidelines: Antidepressants, Benzodiazepines, Gabapentinoids and Z-drugs. London: Wiley-Blackwell; 2024.

[751] Gøtzsche PC. Sundhedsstyrelsens farlige råd om depressionspiller. Politikens Kronik 2020;Feb 7.

[752] Horowitz MA, Taylor D. Tapering of SSRI treatment to mitigate withdrawal symptoms. Lancet Psychiatry 2019;6:538-46.

[753] Gøtzsche PC. Role of health authorities in denying the withdrawal problem with depression drugs. Copenhagen: Institute for Scientific Freedom 2023; Dec 5.

[754] Horowitz MA, Taylor D. Tapering of SSRI treatment to mitigate withdrawal symptoms. Lancet Psychiatry 2019;6:538-46.
[755] Gøtzsche PC. Farlige råd om for hurtig udtrapning af antidepressiva. Ugeskr Læger 2021;183:464.
[756] Lundsgaard CC, Videbech P. Svar. Ugeskr Læger 2021;183:465.
[757] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022.
[758] Ho BC, Andreasen NC, Ziebell S, et al. Long-term antipsychotic treatment and brain volumes: a longitudinal study of first-episode schizophrenia. Arch Gen Psychiatry 2011;68:128-37 and Andreasen NC, Liu D, Ziebell S, et al. Relapse duration, treatment intensity, and brain tissue loss in schizophrenia: a prospective longitudinal MRI study. Am J Psychiatry 2013;170:609-15.
[759] Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022, page 99.
[760] Gøtzsche PC. Psychiatrists roadblock psychiatric drug withdrawal initiatives: Part 1. Breggin.com 2017;Dec 4.
[761] https://www.deadlymedicines.dk/udtrapning-af-psykofarmaka-psychiatric-drug-withdrawal/
[762] Politikerspørgsmål til Region Hovedstaden nr. 227-17 stillet af Niels Høiby besvaret 8. februar 2018.
[763] Peter Gøtzsche & Anders Sørensen om udtrapning af psykofarmaka. Nyborg 2018;March 16.
[764] Davies J, Read J, Hengartner MP, et al. Clinical guidelines on antidepressant withdrawal urgently need updating. BMJ 2019;365:l2238.
[765] Dependence and withdrawal associated with some prescribed medications: an evidence review. Public Health England 2019;Sept.
[766] Davies J, Read J. A systematic review into the incidence, severity and duration of antidepressant withdrawal effects: Are guidelines evidence-based? Addict Behav 2019;97:111-21.
[767] Davies J, Horowitz M, Montagu L, et al. The government has a moral duty to help those harmed by prescribed dependence forming drugs. BMJ 2023;381:p1417.
[768] Nugent T. Profile in courage: A beleaguered whistle-blower physician fights for patients and jobs – and wins. Opednews 2012;Nov 1.
[769] Davies J, Read J. A systematic review into the incidence, severity and duration of antidepressant withdrawal effects: Are guidelines evidence-based? Addict Behav 2019;97:111-21.
[770] Gøtzsche PC, Sørensen A. The review on antidepressant withdrawal that Cochrane won't publish. Mad in America 2020;Feb 11.
[771] Gøtzsche PC. Complaint about Cochrane editors committing editorial misconduct. Copenhagen: Institute for Scientific Freedom 2023;March 29; Gøtzsche PC. Cochrane doesn't take editorial misconduct seriously. Copenhagen: Institute for Scientific Freedom 2023;Aug 31; Gøtzsche PC. Cochrane reviews of psychiatric drugs are untrustworthy. Mad in America 2023;Sept 14.
[772] Korsgaard P, Jensen JH. Producent: Pjat med jer! Afviser afhængighed af lykkepiller: Det kan ikke lade sig gøre. Ekstra Bladet 2012:Dec 11 and Depressionspiller kan gøre brugere afhængige. Politiken 2012;Dec 10.
[773] Gøtzsche PC. Why we need a broad perspective on meta-analysis: It may be crucially important for patients. BMJ 2000;321:585-6.
[774] Cipriani A, Furukawa TA, Salanti G, et al. Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis. Lancet 2018;391:1357-66.
[775] Gøtzsche PC. What is the moral collapse in the Cochrane Collaboration about? Ind J Med Ethics 2019 Oct-Dec;4(4) NS:303-9.
[776] Gøtzsche PC. Complaint about Cochrane editors committing editorial misconduct. Copenhagen: Institute for Scientific Freedom 2023;March 29.
[777] Gøtzsche PC. Cochrane doesn't take editorial misconduct seriously. Copenhagen: Institute for Scientific Freedom 2023;Aug 31.
[778] Van Leeuwen E, van Driel ML, Horowitz MA, et al. Approaches for discontinuation versus continuation of long-term antidepressant use for depressive and anxiety disorders in adults. Cochrane Database Syst Rev 2021;4:CD013495.
[779] Gøtzsche PC, Demasi M. Interventions to help patients withdraw from depression drugs: A systematic review. Int J Risk Saf Med 2024;35:103-16.
[780] Gøtzsche PC, Demasi M. Interventions to help patients withdraw from depression drugs: A systematic review. Int J Risk Saf Med 2024;35:103-16.
[781] Demasi M, Gøtzsche PC. Quitting antidepressants can be tricky Substack 2023;April 25.

[782] Gøtzsche PC, Demasi M. Interventions to help patients withdraw from depression drugs: A systematic review. medRxiv preprint 2023;March 14.
[783] Gøtzsche PC. Cochrane reviews of psychiatric drugs are untrustworthy. Mad in America 2023;Sept 14.
[784] Videos of talks presented at the inaugural symposium. Institute for Scientific Freedom 2019;Mar 9.
[785] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015, page 307.
[786] Whitaker R. Mad in America: bad science, bad medicine, and the enduring mistreatment of the mentally ill. Cambridge: Perseus Books Group; 2002, page 226.
[787] Timimi S. Children's mental health in the era of globalisation: neo-liberalism, commodification, Mcdonaldisation, and the new challenges they pose. In: Victor Olisah (ed), Essential Notes in Psychiatry; 2012.
[788] Gøtzsche PC. Psykofarmaka gör mer skada än nytta, Aftonbladet 2016;Sept 5.
[789] Gøtzsche PC. Antidepressants increase the risk of suicide and violence at all ages. Mad in America 2016;Nov 16.
[790] Gøtzsche PC. Editorial misconduct: Finnish Medical Journal rejects paper on suicide risk. Mad in America 2017;Feb 22.
[791] Whitaker R. Thou shall not criticize our drugs. Mad in America 2017;Sept 22.
[792] Stordrange IL. The happy pill. She survived 10 years of "torture" in psychiatry. Documentary 2017.
[793] Hoel A. Cause of death: unknown. Documentary 2017;Mar 24.
[794] Pedersen AT. Diagnosing psychiatry. Documentary film 2017.
[795] Pedersen AT. Debat: Vi har ret til at undre os. Journalisten 2017;May 8.
[796] Gøtzsche PC. Deadly medicines and organised crime: How big pharma has corrupted health care. London: Radcliffe Publishing; 2013.
[797] https://www.dr.dk/drtv/serie/psykiatriens-dilemma_103834
[798] Pedersen AT. Det, fik du ikke at vide i DRs dokumentar om psykiatri. Psykiatriavisen 2019;June 9.
[799] Christensen AS. DR2 undersøger Danmark på piller. DR 2013;Mar 20.
[800] DR-kampagne undergraver tusinder af lægers arbejde. Dagens Medicin 2013;April 25.
[801] Thouber M. DR taler hverken for eller imod antidepressiv medicin. Dagens Medicin 2013;May 3.
[802] Thomsen PH, Plessen K, Houmann T, et al. DR-serie kan skade børn med ADHD. Dagens Medicin 2013;May 3.
[803] Ditzel EE. Psykiatri-professor om DR-historier: "Skræmmekampagne der kan koste liv." Journalisten 2013;Apr 11.
[804] Gøtzsche PC. Psykiatriprofessors argumentation er misvisende. Politiken 2020; March 13.
[805] Christensen BK. Antidepressiv medicin genopbygger hjernen. Videnskab.dk 2014;Jan 9.
[806] Arnone D, McKie S, Elliott R, et al. State-dependent changes in hippocampal grey matter in depression. Mol Psychiatry 2013;18:1265-72.
[807] Gøtzsche PC. Death of a whistleblower and Cochrane's moral collapse. Copenhagen: People's Press; 2019.
[808] Gøtzsche PC. The decline and fall of the Cochrane empire. Copenhagen: Institute for Scientific Freedom; 2022. Freely available book.
[809] The honest professor and the fall of the Cochrane empire. Documentary film in preparation.
[810] Østergaard K. Mor på antidepressiver begik selvmord. DR1 2013;Apr 15.
[811] Heilbuth PE. Dårlig presseetik, Politiken. Politiken 2013;Apr 19.
[812] Videbech P. Overlæge: DR svigter mennesker med depression. Altinget 2016;Aug 31.
[813] Jensen S. DR: Vi rejser vigtig debat om diagnoser. Altinget 2016;Sept 16.
[814] Gøtzsche PC. The media's false narrative about depression pills, suicides, and saving lives. Mad in America 2023;Aug 23.
[815] Thisted K. Jeg tager lykkepiller, ellers var jeg død! Ekstra Bladet 2015;Oct 24.
[816] Ferrie A. Antidepressants: I wasn't told about the side effects. BBC Scotland 2023;Aug 9.
[817] Gøtzsche PC. Prescription drugs are the leading cause of death. And psychiatric drugs are the third leading cause of death. Mad in America 2024;April 16.
[818] Gøtzsche PC, Gøtzsche PK. Cognitive behavioural therapy halves the risk of repeated suicide attempts: systematic review. J R Soc Med 2017;110:404-10.
[819] Spencer M. The Carter Center's guide for mental health journalism: don't question, follow the script. Mad in America 2020;Feb 23.
[820] Gøtzsche PC. Psykiatri på afveje. Politikens kronik 2014;Jan 6.
[821] Gøtzsche PC. Psychiatry gone astray. Mad in America 2014;Jan 28.

[822] Gøtzsche PC. Deadly medicines and organised crime: How big pharma has corrupted health care. London: Radcliffe Publishing; 2013, page 232.
[823] Schmidt AL. Psykiaterformand: Overlæges forslag vil føre til flere selvmord. Politiken 2014;Jan 6.
[824] Smith E. Farligt at sprede angst om psykofarmaka. Politiken 2014;Jan 16.
[825] Kortegaard L. Lisbeth Kortegaard: Skyd budbringeren – om overforbrug af psykofarmaka. Ugeskr Læger 2014;Jan 21.
[826] Toft ON. Patienter og læger kritiserer Peter Gøtzsche. Altinget 2014;Jan 16.
[827] Schmidt AL. Sundhedsminister: Psykisk syge bliver dobbelt ramt. Politiken 2024;Jan 18.
[828] Smith AL. 870.000 patienter går i rette med overlæge Peter Gøtzsche. Politiken 2014;Jan 14.
[829] Toft ON. Gøtzsche: Jeg siger bare sandheden. Altinget 2014;Jan 16 and Gøtzsche PC. Når sandheden er ilde hørt, skyder man budbringeren. Altinget 2014;Jan 14.
[830] Andreasen JT. Vi ku' afskaffe al medicin of undgå alle bivirkninger. Weekendavisen 2014;Jan 17.
[831] Schmidt AL. Overlæge fortryder centralt udsagn i omblæst kronik: Jeg er blevet misforstået. Politiken 2014;Jan 17.
[832] Villesen K. Polariseret sygdomsdebat. Information 2014;Jan 21.
[833] Bruun CE. Er der en normal dansker til stede? Politiken 2014;Jan 23.
[834] Middelboe T. Debat om psykofarmaka – nu med orkanstyrke. Dansk Psykiatrisk Selskabs Nyhedsbrev 2014;Jan.
[835] Schmidt AL. Psykiaterne går i krig mod overlæge: Peter Gøtzsche er ekstrem og useriøs. Politiken 2014;Jan 17 and Kessing L, Nordentoft M, Middelboe T. Fup og fakta omkring psykofarmaka. Politiken 2014;Jan 17.
[836] Gøtzsche PC. Toneangivende psykiatere er fortsat på afveje. Politiken 2014;Jan 21.
[837] Döllner N. Voldemort. Dagens Medicin 2014;Jan 31.
[838] Heissel A. Peter, the wolf: Gøtzsche versus Gøtzsche. Dagens Medicin 2014;Jan 31.
[839] Kortegaard L. Peter Gøtzsche set gennem Dagens Medicins troldspejl. Dagens Medicin 2014;Feb 28.
[840] Kortegaard L. Lisbeth Kortegaard: Klapjagten på Peter Gøtzsche fortsætter. Ugeskr Læger 2014;May 2.
[841] Licht R, Nordentoft M, Bech P, et al. Ti veje til bedre psykiatrisk behandling. Altinget 2014;Feb 6.
[842] Gøtzsche PC. Psykiatri på afveje. Politikens kronik 2014;Jan 6 and Gøtzsche PC. Psychiatry gone astray. Mad in America 2014;Jan 28.
[843] Gøtzsche PC. Deadly medicines and organised crime: How big pharma has corrupted health care. London: Radcliffe Publishing; 2013.
[844] Schmidt AL. Omstridt professor bliver lagt på is efter angreb på medicin. Politiken 2014;March 25.
[845] Toft ON. Krag: Gøtzsche og Cochrane er ikke det samme. Altinget 2014;Jan 21.
[846] Toft ONM. Gøtzsches organisation tager afstand fra hans psykiatri-udtalelser. Altinget 2014;March 25.
[847] Hemmingsen MA. Internationalt Cochrane-netværk undsiger Peter Gøtzsche. Dagens Medicin 2014;March 28; Schmidt AL. Omstridt professor bliver lagt på is efter angreb på medicin. Politiken 2014;March 25; Larsen K. Cochrane lægger afstand til Gøtzsche. Ugeskr Læger 2014;March 25.
[848] Toft ONM. Gøtzsches organisation tager afstand fra hans psykiatri-udtalelser. Altinget 2014;March 25.
[849] Gøtzsche PC. Cochrane-fjeren, der blev til fem høns. Dagens Medicin 2014;April 11.
[850] Gøtzsche PC. Unwarranted criticism of "Psychiatry cone astray." Mad in America 2014;Feb 20.
[851] Drake RE, Binagwaho A, Martell HC, et al. Mental healthcare in low and middle income countries. BMJ 2014;349:g7086.
[852] Gøtzsche PC. Does long term use of psychiatric drugs cause more harm than good? BMJ 2015;350:h2435.
[853] Tovey D, Churchill R, Adams CE, MacDonald G. Rapid Response to the Maudsley debate. BMJ 2015;May 13.
[854] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015.
[855] Shaw MD. Pernicious low tech issues in healthcare. HealthNewsDigest.com 2015;May 30.
[856] https://www.youtube.com/watch?v=9oH9ovmmAXk
[857] Gøtzsche PC. Rapid response to: Does long term use of psychiatric drugs cause more harm than good? BMJ 2015;May 17.
[858] Gøtzsche PC. Death of a whistleblower and Cochrane's moral collapse. Copenhagen: People's Press; 2019 and Gøtzsche PC. Decline and fall of the Cochrane empire. Copenhagen: Institute for Scientific Freedom; 2022. Freely available.
[859] Vogel G. Fresh fights roil evidence-based medicine group. Science 2018;362:735; Vesper I. Mass resignation guts board of prestigious Cochrane Collaboration. Nature 2018;Sept 17; Enserink M. Evidence-based medicine group in turmoil after expulsion of co-founder. Science 2018;Sept 16; Hawkes N. Cochrane director's expulsion results in four board members resigning. BMJ 2018;17 Sept,362:k3945; Burki T. The Cochrane board votes to

expel Peter Gøtzsche. Lancet 2018;392:1103-4; Hawkes N. Cochrane director says his sacking was flawed and came after "show trial". BMJ 2018;20 Sept,362:k4008.
[860] Timimi S. Death of a whistleblower and Cochrane's moral collapse. Psychosis 2020;12:99-100. Freely available here.
[861] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015.
[862] Rasmussen LI. Industriens markedsføring er meget, meget effektiv. Den har fået lægerne til at tro på, at eksempelvis antidepressiva er effektive lægemidler. Det er de overhovedet ikke. Politiken 2015;Aug 30:PS 8-9 and Rasmussen LI. Dansk psykiatris onde ånd er tilbage. Politiken 2015;Aug 30:4.
[863] Johansen R. Kritisk blikk på psykiatrien. Tidsskrift for Den norske legeforening 2015;135:2201; Nilsson A, "Se upp! Om det behövs: Dra i nödbromsen innan det är för sent!" Psykologtidningen 2016;Nov 3; Due H. Medicinalindustriens dårlige samvittighed. Psykologernes Fagmagasin 2016;2:13-21; Bornäs H. Tonläget är för uppskruvat men kritiken värd att ta på allvar. Filosofi & Psykologi 2017;2:27-9; Oute J, Ringer A. Psykiatrien i krise – en kamp om definitioner. Sygeplejersken 2014;7:78-82; Hedlund F. Peter Gøtzsche på krigsstigen mot psykiatrin. Läkartidningen 2016;113:1448-51.
[864] Barse M. "Peter Gøtzsche: Én mand kan godt ændre videnskaben." videnskab.dk 2015;Nov 13.
[865] Pedersen FS. "Jeg kalder en spade en spade." Berlingske 2015;Nov 22:Magasin:18-9.
[866] Appel MM. Psykiatrien – læger uden grænser. Tidsskriftet Outsideren 2015;Oct 6.
[867] Berglund G. Starka ekonomiska intressen skyddar läkemedelsindustrin. Dala-demokraten 2016;Nov 8 and Sternlycke H. Avslöjanden om psykofarmaka. Miljömagasinet 2016;33:9.
[868] Brinkmann S. Chokerende og læseværdig bog om psykiatriens konsekvenser lider under voldsom retorik. Politiken 2014;Oct 4.
[869] Mysterud I. På pasientenes side mot psykiatrien. Tidsskrift for Norsk psykologforening 2016; 53:396-8; Mysterud I. På pasientenes side mot psykiatrien. Helsemagasinet VOF 2016;March:38-43; Mysterud I. Deadly Psychiatry and Organized Denial. By P. C. Gøtzsche. Psychol Med 2017;47:1335-6.
[870] From HP. En pæn måde at skabe en kronisk patient på. Dagens Medicin 2015;Oct 23.
[871] Flyvbjerg A. Vejen til bedre psykiatri ligger klar foran os. Politiken 2015;Oct 20.
[872] Gøtzsche PC. Psykiatrien. Politiken 2015;Oct 28.
[873] Gøtzsche PC. Usandheder i psykiaterformands boganmeldelse. Ugeskr Læger 2015;Oct 7.
[874] Jacobsen TB. Dødelig psykiatri og organiseret fornægtelse. Ugeskr Læger 2015;Sept 14.
[875] Schmidt AL. "Jeg har fået patienter indlagt, som stoppede med medicin og forsøgte selvmord på grund af den debat, der kørte." Politiken 2015;Sept 5.
[876] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015, page 161.
[877] Rosenberg R. Peter Gøtzsche er ude i et uetisk korstog mod psykisk syge. Politiken 2015;Sept 1.
[878] Madsen MAM. Peter Gøtzsche som nutidens korsridder. Politiken 2015;Sept 5.
[879] Poulsen HD. Psykisk syge i knibe. Politiken 2015;Sept 9.
[880] Mikkelsen JH. Derfor opgiver psykiatere at gå i dialog med Gøtzsche. Dagens Medicin 2015;Oct 23.
[881] Korkeila J. Antipsykiatria 2.0. Suomen Lääkärilehti 2016;39:2465.
[882] Landén M. "Gøtzsches bok är motsatsen till vetenskaplig hederlighet." Läkartidningen 2015;Sept 12.
[883] http://lakartidningen.se/Aktuellt/Kultur/recensioner/2016/09/Antipsykiatri/#comments
[884] Bang JR. Evidensbaseret psykiatrisk behandling, hvad ellers? Ugeskr Læger 2015;177:2155.
[885] Schjøtt F. Psykiatri. Politiken 2015;Oct 29:9 and Schjøtt F. Lundbeck, Lundbeck – über alles. Deadly Medicines 2017;March 2.
[886] Shipko S. Organized denial: psychiatry's quiet desperation. Mad in America 2016;May 1.
[887] Sharfstein S. Big Pharma and American psychiatry: The good, the bad and the ugly. Psychiatric News 2005;40:3.
[888] Davis JM, Giakas WJ, Qu J, et al. Should we treat depression with drugs or psychological interventions? A reply to Ioannidis. Philos Ethics Humanit Med 2011;6:8.
[889] Glenthøj B, Baandrup L, Ebdrup B, et al. Bag myterne om antipsykotisk medicin. Politiken 2012;Oct 19.
[890] Gøtzsche PC. "Make Psychiatry Healthy": Analysis of a leaflet from the Danish Psychiatric Association. Mad in America 2021;Nov 4.
[891] Moore TJ, Glenmullen J, Furberg CD. Prescription drugs associated with reports of violence towards others. PLoS One 2010;5:e15337.
[892] Gøtzsche PC. Brug mindre psykofarmaka, ikke mere. Jyllands-Posten 2023; Sept 14.
[893] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 8.
[894] https://netdoktor.dk/skizofreni/aarsager_til_skizofreni.htm

[895] Trubetskoy V, Pardiñas AF, Qi T, et al. Mapping genomic loci implicates genes and synaptic biology in schizophrenia. Nature 2022;604:502-8.
[896] Rammos A, Gonzalez LAN, The Schizophrenia Working Group of the Psychiatric Genomics Consortium 2, et al. The role of polygenic risk score gene-set analysis in the context of the omnigenic model of schizophrenia. Neuropsychopharmacol 2019;44:1562–9.
[897] Varese F, Smeets F, Drukker M, et al. Childhood adversities increase the risk of psychosis: a meta-analysis of patient-control, prospective- and cross-sectional cohort studies. Schizophr Bull 2012;38:661-71 and Shevlin M, Houston JE, Dorahy MJ, Adamson G. Cumulative traumas and psychosis: an analysis of the national comorbidity survey and the British Psychiatric Morbidity Survey. Schizophr Bull 2008;34:193-9.
[898] Curtis D. Analysis of 50,000 exome-sequenced UK Biobank subjects fails to identify genes influencing probability of developing a mood disorder resulting in psychiatric referral. J Affect Disord 2021;281:216-9.
[899] Torrey F, Simmons WW, Dailey L. The NIMH research portfolio: an update. Psychiatrist.com 2023;Aug 1.
[900] Read J, Haslam N, Sayce L, et al. Prejudice and schizophrenia: a review of the "mental illness is an illness like any other" approach. Acta Psychiatr Scand 2006;114:303-18.
[901] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, chapters 2-4 (freely available).
[902] Deeks JJ, Dinnes J, D'Amico R, et al. Evaluating non-randomised intervention studies. Health Technol Assess 2003;7:1–173.
[903] Ho BC, Andreasen NC, Ziebell S, et al. Long-term antipsychotic treatment and brain volumes: a longitudinal study of first-episode schizophrenia. Arch Gen Psychiatry 2011;68:128-37 and Andreasen NC, Liu D, Ziebell S, et al. Relapse duration, treatment intensity, and brain tissue loss in schizophrenia: a prospective longitudinal MRI study. Am J Psychiatry 2013;170:609-15.
[904] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 21.
[905] Barber M. Strengthening research integrity: The role and responsibilities of publishing. International Science Council 2021; Nov 3.
[906] Timimi S. Insane medicine: How the mental health industry creates damaging treatment traps and how you can escape them. Seattle: Kindle Direct Publishing; 2021.
[907] Frankfurt HG. On bullshit. New Jersey: Princeton University Press; 2005.
[908] Kahnemann D. Thinking, fast and slow. London: Penguin Books; 2011.
[909] Gøtzsche PC. Psychiatry textbooks are filled with errors and propaganda. Copenhagen: Institute for Scientific Freedom 2022;Aug 3.
[910] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022.
[911] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015 and Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022.
[912] de Vries YA, Roest AM, de Jonge P, et el. The cumulative effect of reporting and citation biases on the apparent efficacy of treatments: the case of depression. Psychol Med 2018;48:2453-5 and Boutron I, Dutton S, Ravaud P, et al. Reporting and interpretation of randomized controlled trials with statistically nonsignificant results for primary outcomes. JAMA 2010;303:2058-64.
[913] Moncrieff J, Cohen D. Do antidepressants cure or create abnormal brain states? PLoS Med 2006;3:e240.
[914] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015; Hróbjartsson A, Thomsen AS, Emanuelsson F, et al. Observer bias in randomised clinical trials with binary outcomes: systematic review of trials with both blinded and non-blinded outcome assessors. BMJ 2012;344:e1119; Hróbjartsson A, Thomsen ASS, Emanuelsson F, et al. Observer bias in randomized clinical trials with measurement scale outcomes: a systematic review of trials with both blinded and nonblinded assessors. CMAJ 2013;185:E201-11.
[915] Cole JO. Phenothiazine treatment in acute schizophrenia; effectiveness: the National Institute of Mental Health Psychopharmacology Service Center Collaborative Study Group. Arch Gen Psychiatry 1964;10:246-61.
[916] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paper-backs; 2015.
[917] Gronfein W. Psychotropic drugs and the origins of deinstitutionalization. Social Problems 1985;32:437-54.
[918] Boesen K, Gøtzsche PC, Ioannidis JPA. EMA and FDA psychiatric drug trial guidelines: assessment of guideline development and trial design recommendations. Epidemiol Psychiatr Sci 2021;30:e35,1–10.
[919] Leucht S, Tardy M, Komossa K, et al. Antipsychotic drugs versus placebo for relapse prevention in schizophrenia: a systematic review and meta-analysis. Lancet 2012;379:2063-71.
[920] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022, page 55.

[921] Wunderink L, Nieboer RM, Wiersma D, et al. Recovery in remitted first-episode psychosis at 7 years of follow-up of an early dose reduction/discontinuation or maintenance treatment strategy: long-term follow-up of a 2-year randomized clinical trial. JAMA Psychiatry 2013;70:913-20.
[922] Hui CLM, Honer WG, Lee EHM, et al. Long-term effects of discontinuation from antipsychotic maintenance following first-episode schizophrenia and related disorders: a 10 year follow-up of a randomised, double-blind trial. Lancet Psychiatry 2018;5:432-42; Chen EY, Hui CL, Lam MM, et al. Maintenance treatment with quetiapine versus discontinuation after one year of treatment in patients with remitted first episode psychosis: randomised controlled trial. BMJ 2010;341:c4024; Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022, page 32.
[923] Breggin P. Psychiatric drug withdrawal: A guide for prescribers, therapists, patients and their families. New York: Springer; 2012.
[924] Danborg PB, Simonsen AL, Hróbjartsson A, Gøtzsche PC. Long-term changes in observed behaviour after exposure to psychiatric drugs: a systematic review of animal studies. Institute for Scientific Freedom 2017;Nov 26.
[925] Whitaker R, Gøtzsche PC. The pervasive financial and scientific corruption of psychiatric drug trials. Copenhagen: Institute for Scientific Freedom 2022;Mar 23.
[926] Insel TR. Psychiatrists' relationships with pharmaceutical companies: part of the problem or part of the solution? JAMA 2010;303:1192-3; Harris G, Carey B, Roberts J. Psychiatrists, children and drug industry's role. New York Times 2007;May 10; Moynihan R. Is the relationship between pharma and medical education on the rocks? BMJ 2008;337:484-5.
[927] Campbell EG, Weissman JS, Ehringhaus S, et al. Institutional academic industry relationships. JAMA 2007;298:1779-86.
[928] Gøtzsche PC. Deadly medicines and organised crime: How big pharma has corrupted health care. London: Radcliffe Publishing; 2013 and Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015.
[929] Schelin EM. Sund skepsis er den bedste medicin. Ugeskr Læger 2010;172:3361.
[930] Insel T. Healing: our path from mental illness to mental health. New York: Penguin Press; 2022.
[931] Whitaker R. Thomas Insel makes a case for abolishing psychiatry. Mad in America 2022;Apr 30.
[932] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015.
[933] Whitaker R. Thomas Insel makes a case for abolishing psychiatry. Mad in America 2022;Apr 30.
[934] Schopenhauer A. The art of always being right. London: Gibson Square; 2009.
[935] Levine B. How to explain top psychiatrists' "Dr. Strangelove exuberance" unchecked by reality. Mad in America 2025;June 6.
[936] Bockoven JS, Solomon HC. Comparison of two five-year follow-up studies: 1947 to 1952 and 1967 to 1972. Am J Psychiatry 1975;132:796-801.
[937] Carpenter WT, McGlashan TH, Strauss JS. The treatment of acute schizophrenia without drugs: an investigation of some current assumptions. Am J Psychiatry 1977;134:14-20.
[938] Bola JR, Mosher LR. Treatment of acute psychosis without neuroleptics: two-year outcomes from the Soteria project. J Nerv Ment Dis 2003;191:219-29.
[939] Rappaport M, Hopkins HK, Hall K, et al. Are there schizophrenics for whom drugs may be unnecessary or contraindicated? Int Pharmacopsychiatry 1978;13:100-11.
[940] Chouinard G, Jones BD. Neuroleptic-induced supersensitivity psychosis: clinical and pharmacologic characteristics. Am J Psychiatry 1980;137:16-21.
[941] Ho BC, Andreasen NC, Ziebell S, et al. Long-term antipsychotic treatment and brain volumes: a longitudinal study of first-episode schizophrenia. Arch Gen Psychiatry 2011;68:128-37 and Ho BC, Andreasen NC, Nopoulos P, et al. Progressive structural brain abnormalities and their relationship to clinical outcome: a longitudinal magnetic resonance imaging study early in schizophrenia. Arch Gen Psychiatry 2003;60:585-94.
[942] Harrow M, Jobe TH. Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications: a 15-year multifollow-up study. J Nerv Ment Dis 2007;195:406-14.
[943] Wunderink L, Nieboer RM, Wiersma D, et al. Recovery in remitted first-episode psychosis at 7 years of follow-up of an early dose reduction/discontinuation or maintenance treatment strategy: long-term follow-up of a 2-year randomized clinical trial. JAMA Psychiatry 2013;70:913-20.
[944] Moilanen J, Haapea M, Miettunen J, et al. Characteristics of subjects with schizophrenia spectrum disorder with and without antipsychotic medication - a 10-year follow-up of the Northern Finland 1966 Birth Cohort study. Eur Psychiatry 2013;28:53-8.

[945] Gleeson JF, Cotton SM, Alvarez-Jimenez M, et al. A randomized controlled trial of relapse prevention therapy for first-episode psychosis patients: outcome at 30-month follow-up. Schizophr Bull 2013;39:436-48.
[946] Wils RS, Gotfredsen DR, Hjorthøj C, et al. Antipsychotic medication and remission of psychotic symptoms 10 years after a first-episode psychosis. Schizophr Res 2017;182:42-8.
[947] Jung E, Wiesjahn M, Wendt H, et al. Symptoms, functioning and coping strategies in individuals with schizophrenia spectrum disorders who do not take antipsychotic medication: a comparative interview study. Psychol Med 2016;46:2179-88..
[948] Bjornestad J, Lavik KO, Davidson L, et al. Antipsychotic treatment - a systematic literature review and meta-analysis of qualitative studies. J Ment Health 2020;29:513-23.
[949] Whitaker R. Drug info: Adults. Antidepressants. Mad in America. Undated.
[950] Pigott HE, Leventhal AM, Alter GS, et al. Efficacy and effectiveness of antidepressants: current status of research. Psychother Psychosom 2010;79:267-79.
[951] Posternak MA, Solomon DA, Leon AC, et al. The naturalistic course of unipolar major depression in the absence of somatic therapy. J Nerv Ment Dis 2006;194:324-9.
[952] Shea MT, Elkin I, Imber SD, et al. Course of depressive symptoms over follow-up. Findings from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. Arch Gen Psychiatry 1992;49:782-7.
[953] Coryell W, Endicott J, Winokur G, et al. Characteristics and significance of untreated major depressive disorder. Am J Psychiatry 1995;152:1124-9.
[954] Goldberg D, Privett M, Ustun B, et al. The effects of detection and treatment on the outcome of major depression in primary care: a naturalistic study in 15 cities. Br J Gen Pract 1998;48:1840-4.
[955] Dewa CS, Hoch JS, Lin E, et al. Pattern of antidepressant use and duration of depression-related absence from work. Br J Psychiatry 2003;183:507-13.
[956] Patten SB. The impact of antidepressant treatment on population health: synthesis of data from two national data sources in Canada. Popul Health Metr 2004;2:9.
[957] Vittengl JR. Poorer long-term outcomes among persons with major depressive disorder treated with medication. Psychother Psychosom 2017;86:302-4.
[958] Hengartner MP, Angst J, Rössler W. Antidepressant use prospectively relates to a poorer long-term outcome of depression: results from a prospective community cohort study over 30 years. Psychother Psychosom 2018;87:181-3.
[959] Fava GA. Do antidepressant and antianxiety drugs increase chronicity in affective disorders? Psychother Psychosom 1994;61:125-31; [959] Fava GA. Holding on: depression, sensitization by antidepressant drugs, and the prodigal experts. Psychother Psychosom 1995;64:57-61; Fava GA. Potential sensitising effects of antidepressant drugs on depression. CNS Drugs 1999;4:247-56; Fava GA. Can long-term treatment with antidepressant drugs worsen the course of depression? J Clin Psychiatry 2003;64:123-33.
[960] El-Mallakh RS, Gao Y, Jeannie Roberts R. Tardive dysphoria: the role of long term antidepressant use in-inducing chronic depression. Med Hypotheses 2011;76:769-73.
[961] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015 and Whitaker R. Den psykiatriske epidemi: Illusionen om mirakelpillen. Søborg: Psykovisions Forlag; 2013, page 24 (more countries are included in the Danish version).
[962] Raine ADHD Study: Long-term outcomes associated with stimulant medication in the treatment of ADHD in children. Government of Western Australia 2010; Feb 7.
[963] Currie J, Stabile M, Jones LE. Do stimulant medications improve educational and behavioral outcomes for children with ADHD? National Bureau of Economic Research 2013;June.
[964] Questions and answers about the NIMH Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study — Level 1 results, published in American Journal of Psychiatry · January 1, 2006. NIMH press release 2006;Jan.
[965] The Multimodal Treatment of Attention Deficit Hyperactivity Disorder Study (MTA): Questions and answers. NIMH 2009;Nov.
[966] Whitaker R, Cosgrove L. Psychiatry under the influence: institutional corruption, social injury, and prescriptions for reform. New York: Palgrave Macmillan; 2015.
[967] Wikler D. "A crisis in medical professionalism." In: Ethics and the Business of Biomedicine (Arnold D, ed.). New York: Cambridge University Press; 2009, page 253.
[968] Gøtzsche PC. About not listening to people. Mad in America 2023;March 1.
[969] Read J. How psychiatrists responded to the launch of our new ECT survey. Mad in America 2024;Feb 29.

[970] Mikkel S. Vejen ud af skizofreni Tidsskriftet Outsideren 2016;Feb 14.
[971] Timimi S. Insane medicine: How the mental health industry creates damaging treatment traps and how you can escape them. Seattle: Kindle Direct Publishing; 2021.
[972] Collin S, Rowse G, Martinez AP, et al. Delusions and the dilemmas of life: A systematic review and meta-analyses of the global literature on the prevalence of delusional themes in clinical groups. Clin Psychol Rev 2023;104:102303.
[973] Whitaker R. Anatomy of an Epidemic. New York: Broadway Paperbacks; 2010, page 319.
[974] Gøtzsche PC. Critical psychiatry textbook. Copenhagen: Institute for Scientific Freedom; 2022; Santaguida P, MacQueen G, Keshavarz H, et al. Treatment for depression after unsatisfactory response to SSRIs. Comparative effectiveness review No. 62. (Prepared by McMaster University Evidence-based Practice Center under Contract No. HHSA 290 2007 10060 I.) AHRQ Publication No.12-EHC050-EF. Rockville, MD: Agency for Healthcare Research and Quality; 2012:April; Rink L, Braun C, Bschor T, et al. Dose increase versus unchanged continuation of antidepressants after initial antidepressant treatment failure in patients with major depressive disorder: a systematic review and meta-analysis of randomized, double-blind trials. J Clin Psychiatry 2018;79;17r11693; Samara MT, Klupp E, Helfer B, et al. Increasing antipsychotic dose for non response in schizophrenia. Cochrane Database Syst Rev 2018;5:CD011883.
[975] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015; Miller M, Swanson SA, Azrael D, Pate V, Stürmer T. Antidepressant dose, age, and the risk of deliberate self-harm. JAMA Intern Med 2014;174:899-909; Ho BC, Andreasen NC, Ziebell S, et al. Long-term antipsychotic treatment and brain volumes: a longitudinal study of first-episode schizophrenia. Arch Gen Psychiatry 2011;68:128-37; Zipursky RB, Reilly TJ, Murray RM. The myth of schizophrenia as a progressive brain disease. Schizophr Bull 2013;39:1363-72.
[976] Mojtabai R, Olfson M. National trends in psychotropic medication polypharmacy in office-based psychiatry. Arch Gen Psychiatry 2010;67:26-36.
[977] Wood SJ, Ilomäki J, Gould J, et al. Dispensing of psychotropic medications to Australian children and adolescents before and during the COVID-19 pandemic, 2013-2021: a retrospective cohort study. Med J Aust 2023;219:18-25.
[978] Klau J, Gonzalez-Chica D, Raven M, et al. Antipsychotic prescribing patterns in children and adolescents attending Australian general practice in 2011 and 2017. JCPP Adv 2023;4:e12208.
[979] Ilyas S, Moncrieff J. Trends in prescriptions and costs of drugs for mental disorders in England, 1998-2010. Br J Psychiatry 2012;200:393-8.
[980] Nielsen M, Gøtzsche P. An analysis of psychotropic drug sales. Increasing sales of selective serotonin reuptake inhibitors are closely related to number of products. Int J Risk Saf Med 2011;23:125-32.
[981] Saha S, Chant D, McGrath J. A systematic review of mortality in schizophrenia: is the differential mortality gap worsening over time? Arch Gen Psychiatry 2007;64:1123-31.
[982] Forbruget af antipsykotika blandt 18-64 årige patienter, med skizofreni, mani eller bipolar affektiv sindslidelse. København: Sundhedsstyrelsen; 2006.
[983] Notat om dosering af lægemidler i psykiatrien. Ministeriet for Sundhed og Forebyggelse 2014;Oct 30.
[984] Joukamaa M, Heliövaara M, Knekt P. Schizophrenia, neuroleptic medication and mortality. Br J Psychiatry 2006;188:122-7; Tenback D, Pijl B, Smeets H. All-cause mortality and medication risk factors in schizophrenia. J Clin Psychopharmacol 2012;32:31-5; Waddington JL, Youssef HA, Kinsella A. Mortality in schizophrenia. Antipsychotic polypharmacy and absence of adjunctive anticholinergics over the course of a 10-year prospective study. Br J Psychiatry 1998;173:325-9; Ray WA, Meredith S, Thapa PB, et al. Antipsychotics and the risk of sudden cardiac death. Arch Gen Psychiatry 2001;58:1161-7; Ray WA, Chung CP, Murray KT, et al. Atypical antipsychotic drugs and the risk of sudden cardiac death. N Engl J Med 2009;360:225-35.
[985] Christensen DC. Dear Luise: a story of power and powerlessness in Denmark's psychiatric care system. Portland: Jorvik Press; 2012.
[986] Lien L, Reitan SK, Halvorsen NJN, et al. "Pilleskam" i psykiatrien er et alvorlig samfunnsproblem. Aftenposten 2023;Aug 10.
[987] Gøtzsche PC. The media's false narrative about depression pills, suicides, and saving lives. Mad in America 2023;Aug 23.
[988] Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015, page 163.
[989] Rodriguez-Martin JL, Barbanoj JM, Schlaepfer T, et al. Transcranial magnetic stimulation for treating depression. Cochrane Database Syst Rev 2002;2;CD003493.
[990] Videos from International meeting: Psychiatric drugs do more harm than good. Copenhagen 2015;Sept 16.

[991] Gøtzsche PC. Long-term use of antipsychotics and antidepressants is not evidence-based. Int J Risk Saf Med 2020;31:37-42.
[992] Kroken RA, Kjelby E, Wentzel-Larsen T, et al. Time to discontinuation of antipsychotic drugs in a schizophrenia cohort: influence of current treatment strategies. Ther Adv Psychopharmacol 2014;4:228-39.
[993] Gøtzsche PC. Long-term use of benzodiazepines, stimulants and lithium is not evidence-based. Clin Neuropsychiatry 2020;17:281-3.
[994] Gøtzsche PC. Survival in an overmedicated world: look up the evidence yourself. Copenhagen: People's Press; 2019, page 116.
[995] Poulsen HD. 2014: Året hvor patienten bliver taber. Berlingske 2013;Dec 26:37.
[996] Gøtzsche PC. Medicinalindustriens mange løgne. Jyllands-Posten 2014;Jan 4.
[997] Kendt psykiater betalt af pilleindustrien. MX.dk 2014;Jan 24.
[998] Gøtzsche PC. Days tomme postulater om psykiatrien. Berlingske 2015;Sept 12:16.
[999] Kortegaard L. Demagogi eller heksejagt: hvad er værst? Berlingske 2014;Aug 23.
[1000] Poulsen HP. Heksejagt på medicinalindustri. Berlingske 2016;Aug 12.
[1001] Larsen K. Voldgiftsret giver Gøtzsche medhold i strid med Day Poulsen. Ugeskr Læger 2014;Nov 19.
[1002] Nielsen AS, Kortegaard LS. Korrupt og paranoid kronik. Berlingske 2014;Jan 10.
[1003] Schmidt AL. Kendt psykiater: Tredobbelt dosis medicin er helt okay. Politiken 2014;Sept 9.
[1004] Critical Psychiatry Network
[1005] Winn D. Time to rethink psychiatry. Human Givens Journal 2015;22:28-32.
[1006] Middleton H. Psychiatry reconsidered: from medical treatment to supportive understanding. London: Palgrave Macmillan; 2015.
[1007] Moraros J, Nwankwo C, Patten SB, Mousseau DD. The association of antidepressant drug usage with cognitive impairment or dementia, including Alzheimer disease: A systematic review and meta-analysis. Depress Anxiety 2017;34:217-26 and Coupland CAC, Hill T, Dening T, et al. Anticholinergic drug exposure and the risk of dementia: a nested case-control study. JAMA Intern Med 2019;Jun 24.
[1008] Holmgren A, Gøtzsche PC. Psykiatrien bør ændres radikalt: Danmark skal have tvangsfrie hospitaler. Jyllands-Posten 2024;April 1.
[1009] Sherlock C. Adaption practice.
[1010] Drachmann H. Klinikchef må ikke længere arbejde som psykiater. Politiken 2013;Feb 1.
[1011] Hildebrandt S. "Det er monstrøse doser af medicin." Dagens Medicin 2015;Oct 23.
[1012] Hildebrandt S. Lars Søndergård mistænkes atter for at overmedicinere. Dagens Medicin 2015;Oct 23.
[1013] Schmidt M. Svar fra ledelsen i Psykiatrien Vest. Dagens Medicin 2015;Oct 23.
[1014] Hildebrandt S. Derfor er Lars Søndergårds supervisor sat under skærpet tilsyn. Dagens Medicin 2016;Mar 3.
[1015] Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022, page 147.
[1016] Striden om de antidepressiva medlen. Sveriges radio 2017;Aug 28.
[1017] Svensson P. Så stoppade GU-professor allmänhetens insyn i läkemedelsforskning. Göteborgs-posten 2018;Jan 20 and Sternbeck P. Brallorna nere på professorn Elias Eriksson. Equal 2018;Jan 16.
[1018] Riksdagens Ombudsman. Kritik mot Göteborgs universitet for handläggningen av en begäran om utlämnande av allmänna handlingar m.m. 2017;Dec 20:Dnr 7571-2016.
[1019] Gøtzsche PC. A new paradigm for testing psychiatric drugs is needed. Mad in America 2023;Feb 25.
[1020] Gøtzsche PC. How peer reviewers and editors protected a failed paradigm for psychiatric drug testing. Mad in America 2023;March 10.
[1021] Whitaker R. Mad in America: bad science, bad medicine, and the enduring mistreatment of the mentally ill. Cambridge: Perseus Books Group; 2002.
[1022] Whitaker R. Anatomy of an epidemic, 2nd edition. New York: Broadway Paperbacks; 2015.
[1023] Moore J. Robert Whitaker answers reader questions on Mad in America, the biopsychosocial model, and psychiatric history. Mad in America 2023;Dec 13.
[1024] Unrecognised facts about modern psychiatric practice. Council for Evidence-based Psychiatry 2014;Apr 16.
[1025] Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022 (Dick Bijl, on the first page after the cover page).
[1026] Brogaard M. Depressive eksperimenterer med medicinen. Videnskab.dk 2014;Dec 28.
[1027] Coombes R. Having the last laugh at big pharma. BMJ 2007;334:396–7 and https://www.youtube.com/watch?v=sQw_cdhXGco.
[1028] Motivational Deficiency Disorder. Video.

[1029] Moynihan R. Scientists find new disease: motivational deficiency disorder. BMJ 2006;332:745.
[1030] Broken Medical Science. Institute for Scientific Freedom. Podcast series.
[1031] Film about the lack of scientific freedom. Donations can be made via this website.
[1032] Dr Peter Gøtzsche exposes big pharma as organized crime.
[1033] Deep throat. The Daily Show 2014;Sept 16.
[1034] Pedersen AT. Diagnosing psychiatry. Documentary film 2017.
[1035] Film about the lack of scientific freedom. Donations can be made via this website.